# California Health and Human Services Agency Department of Health Services Managed Risk Medical Insurance Board



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Diana M. Bontá Director Department of Health Services Grantland Johnson Secretary California Health and Human Services Agency

> Sandra Shewry Executive Director Managed Risk Medical Insurance Board

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### **Executive Summary**

This report identifies five options for streamlining application and enrollment processes for Medi-Cal for Children (MCC) and the Healthy Families Program (HFP) through coordination with other public programs, including the Food Stamps Program, Supplemental Nutrition Program for Women, Infants and Children (WIC), and the National School Lunch Program (NSLP). These are viable options under current Federal and State statute and regulations governing MCC and HFP.

Streamlining application and enrollment processes for MCC and HFP is a critical strategy for increasing enrollment of uninsured and eligible children into these programs. An important and shared goal of MCC and HFP is to make the application and enrollment process for both programs as consumer-friendly and efficient as possible, so that children receive immediate access to preventive and medical services.

Access to health insurance for pregnant women, infants and children is one of the most important factors in reducing low-weight births and infant mortality, and in ensuring that children get the health care they need to have healthy minds and bodies. Numerous studies show that there are consequences for children not having health insurance. Uninsured children are less likely to receive medical care when sick or injured, to have a regular source of health care, to be fully immunized, to have medical care and well-child visits, and to obtain dental care. In addition, uninsured children are more likely to be sick upon admission to a hospital, to use more resources during hospitalization, and to suffer from higher mortality rates while in the hospital. Notwithstanding the burden on these children and their families, there are costs to the health care system and society as well for providing primary care to the uninsured in hospital emergency rooms.

The consequences for children of not having health insurance are not limited to poor health outcomes. Access to health care is important to children's ability to succeed in school. Research shows that children's early physical and mental health is important to their later readiness for school and school success.<sup>3</sup> Students who frequently are absent for health reasons, or who suffer from health problems, may not perform as well in school.<sup>4</sup>

Improved coordination between MCC and HFP is a key step towards streamlining enrollment of uninsured, eligible children into these programs. Applicants to either program should be assessed for eligibility and enrolled in the appropriate program without delay and burdensome, duplicative requirements. MCC and HFP are exploring opportunities to build upon current efforts to improve coordination and streamline application and enrollment processes for the programs. One example is the Health-e-App, the nation's first online enrollment system for public health programs, which is a

<sup>&</sup>lt;sup>1</sup> All cited in National Maternal and Child Health Policy Consortium, "Facts About Uninsured Children," July 1997.

<sup>&</sup>lt;sup>2</sup> Hadley, Steinberg and Feder. "Comparison of uninsured and privately insured hospital patients. Condition on admission, resource use, and outcome." *JAMA*, 1991, Jan 16, 265(3): 374-9.

<sup>&</sup>lt;sup>3</sup> Child Trends, "School Readiness: Helping Communities Get Children Ready for School and Schools Ready for Children," August 2000.

<sup>&</sup>lt;sup>4</sup> Symons, C.W., et al, "Bridging Student Health Risks and Academic Achievement Through Comprehensive School Health Programs," *Journal of School Health*, August 1997, 67:6, p 220.

promising pilot project that could be implemented statewide in a variety of sites frequented by children and families.

Another promising approach is to streamline MCC and HFP application and enrollment processes for children applying to, or already enrolled in, other public programs. Often called "Express Lane Eligibility," this approach seeks to expedite enrollment for children who, in many cases, have already provided contact, income and other eligibility information to another public program, particularly those with income requirements that are similar to those of MCC and HFP.

Streamlining enrollment through coordination with other income-tested programs makes sense because many children enrolled in these other programs are very likely income eligible for either MCC or HFP. It is estimated that over 700,000 uninsured children in California are potentially eligible for MCC or HFP and enrolled already in at least one of the following programs: Food Stamps, WIC, or NSLP.<sup>5</sup>

State administrative data for the Food Stamps and WIC programs indicate that many children in these programs are not enrolled in MCC or HFP currently, though it is unknown whether these children have another source of health insurance. Food Stamps program data confirm that there are about 46,000 children receiving Food Stamps who are not enrolled in either MCC or HFP. These children are very likely eligible for MCC or HFP since the maximum income eligibility levels for Food Stamps are lower than those of MCC and HFP. Administrative data also show that about 285,000 children participating in WIC are not enrolled in MCC. To complete this picture, a data match is underway to determine how many of these children are already enrolled in HFP. All WIC children are very likely income eligible for either MCC or HFP, although they may not meet the more restrictive citizenship and immigration requirements of those programs.

The five options presented in this report vary in the extent to which each would expedite the MCC/HFP enrollment process by making it less burdensome for applicants. Implementation of the options could occur in combination with one another through a single program or multiple programs.

Not included among the five options presented in this report is a "deeming" approach, whereby a child enrolled in another program with eligibility requirements similar to those of MCC and HFP could be deemed to have met the eligibility requirements for participation in MCC or HFP. Under this approach, a child would be deemed *income eligible* for MCC or HFP, or *fully eligible* for MCC or HFP depending upon how closely the program's eligibility requirements align with those of MCC and HFP. There are a number of Federal and State statutes and regulations, however, which affect the

<sup>6</sup> Individual-level data for NSLP is not maintained at the State level, so it is not possible to match data to determine how many children served through NSLP are currently enrolled in MCC or HFP.

<sup>&</sup>lt;sup>5</sup> "Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children in Medi-Cal and Healthy Families," A Publication of the 100% Campaign (a collaborative effort of Children Now, Children's Defense Fund, and the Children's Partnership), February 2000, pp. 2-3.

These children are receiving non-assistance Food Stamps, which means that they are not participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Children receiving CalWORKs are automatically eligible for MCC.

feasibility of deeming for MCC and HFP. An examination of these statutes and regulations reveals that the deeming approach is not feasible currently for any of the programs discussed in this report. *None* of the programs has eligibility requirements and determination methods that, *for every* participant, are equal to or more restrictive than those of MCC/HFP. The Food Stamps program is closest to meeting this standard. Federal flexibility and modifications in State policy would be needed to permit deeming of MCC/HFP eligibility for Food Stamps participants. The challenges of deeming are discussed further in <a href="Chapter 3">Chapter 3</a> and <a href="Appendix1">Appendix 1</a>.

### The five options include:

Option A: Referrals with Follow-up Capability

Option B: On-site Application Assistance

Option C: Common Application

Option D: Sharing Eligibility Information

Option E: Presumptive Eligibility

Each option is described briefly in this section. <u>Chapter 3</u> provides further information about the implications of implementation of each option.

### Option A: Referrals with Follow-up Capability

Establish and enhance referral processes between other programs and schools, and MCC/HFP. Ideally, a referral would provide MCC/HFP and/or community-based enrollment entities and certified application assistants (CAAs) with contact information for families so that appropriate follow-up activities can occur.

Many Federal and State programs encourage, and in some cases require, local program sites to conduct referrals to MCC/HFP as part of a larger effort to help children and families access other services that will meet their needs. Programs that *require* referrals to MCC/HFP include: WIC, Child Care, State Preschool, and CHDP (for programs). Programs that *encourage* MCC/HFP referrals include: Food Stamps, CHDP (for providers), Head Start, Healthy Start, and ABC projects. In addition, some schools provide MCC/HFP referrals, often targeted to children served in the NSLP, with assistance from community-based organizations and school-based programs such as Healthy Start and Head Start. Most referrals currently include inquiring about children's and families' health insurance status, informing and educating families about MCC/HFP and the benefits of health care coverage, disseminating application materials, and informing families of how to contact CAAs in their area.

These referrals could both be expanded to more programs and local program sites, and enhanced to be more effective. First, referrals could be conducted on a regular basis through *all local sites* of programs that currently encourage referrals, as well as other programs that have not yet encouraged referrals on a large-scale basis (i.e., Child Support, Child Care Food, Alcohol and Other Drug Programs, Mental Health Services, Developmental Services Regional Centers, Child Welfare Services, and Unemployment

Insurance). In addition, more school districts and schools could conduct referrals with assistance from school-based programs and community-based partners.

Second, the referral approach could be more effective if it included the collection of family contact information so that MCC/HFP, community-based enrollment entities and/or CAAs could follow up with families to complete enrollment. Often, families need multiple contacts with MCC/HFP for them to complete the application and enrollment processes. Programs and schools could obtain parental consent to share a family's contact information with MCC/HFP or a local CAA. To facilitate this process, MCC/HFP would work with programs to develop a new form, or modify existing forms, so that parents would have an opportunity to grant consent for the release of their contact information. Another approach would be for MCC/HFP to create a standard referral process whereby all programs and schools could distribute an official MCC/HFP referral form. Parents would complete and return the form to the program or school, or mail it in a pre-paid postage envelope to another location, to request a MCC/HFP application and assistance. The forms would be forwarded to the appropriate entities (i.e., MCC/HFP. community-based enrollment entities or CAAs) for follow-up with families. Some schools and school districts have partnered with community-based organizations and county Medi-Cal offices to use this approach. Examples are provided in the School Health Connections profile in Appendix E.

Fifteen programs indicate that it would be possible to create or enhance an existing referral mechanism (that would include a capacity for follow-up) between their programs and MCC/HFP. These programs include: Food Stamps, CHDP, WIC, NSLP, Child Care, State Preschool, Child Care Food, Head Start, Child Support, Developmental Services Regional Centers, Mental Health Services, Alcohol and Other Drug Programs, Child Welfare Services, ABC Projects, and Unemployment Insurance. Four of these programs (NSLP, Child Care, State Preschool and Child Care Food) express a strong preference for having families complete a new, separate referral form, rather than revise their existing application forms to enable parents to grant consent for the release of their contact information. Finally, for school districts and schools, a referral process is a promising option whether or not the referral is connected to the NSLP. Community-based organizations and school-based programs such as Healthy Start and Head Start could assist with such referral activities.

### Option B: On-site Application Assistance

Provide education and on-site application assistance for MCC/HFP at the other program and school locations.

Various schools and local sites of some programs currently provide MCC/HFP education and on-site application assistance to families. Programs and schools may use their own staff and/or provide space for out-stationed county Medi-Cal eligibility workers (EWs) or local CAAs to conduct these activities. This practice could be expanded to include more schools, programs, and local sites. In addition, on-site assistance could be enhanced through implementation of the Health-e-App and related personal assistance at various program locations and school sites statewide.

Twelve programs indicate that it would be possible to provide on-site assistance at their local sites. These programs include: Food Stamps, WIC, CHDP, Head Start, Child Care Food, Child Care, State Preschool, Child Support, Alcohol and Other Drug Programs, Mental Health Services, ABC Projects and Developmental Services Regional Centers. In addition, it would be possible to provide on-site assistance at schools with assistance from community-based organizations and school-based programs such as Healthy Start and Head Start.

### Option C: Common Application

Use a common application to collect income and other eligibility information simultaneously for MCC, HFP, and other programs.

Common applications allow for the implementation of a "no-wrong-door model" whereby individuals and families would be able to apply for multiple programs by coming through the door of any program site.<sup>8</sup> A common application for multiple programs could be paper-based or automated.

Simplicity and length are key considerations in the development of a common paper-based application. Each program has specific, and often unique, information that must be collected for eligibility determination. Consolidation of multiple applications into one form must include an effort to remove duplicative questions and standardize eligibility requirements; otherwise the application could become very complex and cumbersome for applicants.

At this time, a common paper application is not feasible for most programs due to several reasons. Several programs (NSLP, Child Care, State Preschool, Head Start, and ABC projects) give local sites discretion to design their own application forms. Other programs (CHDP, Child Support, Mental Health Services, Alcohol and Other Drug Programs, Child Welfare Services, and Unemployment Insurance), either do not enroll individuals using a process like that used by MCC/HFP, or use a variety of intake methods or forms. A common paper application could be used with the Food Stamps and Child Care Food programs.

The development of a common automated application could be explored further with a core group of programs that have automated systems such as CalWORKs, Food Stamps and WIC. One challenge for CalWORKs and Food Stamps is that counties administer these programs using one of four automated systems, which are not linked statewide. At this time, the WIC program is the only program that has a common statewide, automated system that could be linked to other programs.

One alternative could be to build on the Health-e-App system to create a common automated application for MCC, HFP, and other programs. While Health-e-App is a

<sup>9</sup> Currently, a common paper-based application is used for the CalWORKs, Food Stamps and Medi-Cal programs. In addition, MCC and HFP use a joint application.

<sup>&</sup>lt;sup>8</sup> In the absence of a common application, some counties have developed a uniform screening form, which is used by multiple programs to conduct appropriate needs assessments and referrals. Like a common application, a uniform screening form helps ensure that children are linked to all necessary services and supports.

promising model for MCC and HFP, further research and evaluation would be needed to determine how other programs could be added.

### Option D: Sharing Eligibility Information

Other programs with income requirements similar to those of MCC/HFP could obtain parental consent to share with MCC/HFP the income and other eligibility information families already provided to those programs. MCC/HFP would use this information to initiate the MCC/HFP application process. MCC/HFP would obtain from the family only the additional information needed to complete enrollment. Other programs would not collect any additional information required from MCC/HFP, such as citizenship or immigration status. Obtaining such information from families for eligibility determination would be the responsibility of MCC/HFP.

Of the five options presented in this report, this approach would streamline the enrollment process for applicants the most. Families would not need to provide duplicative information for MCC/HFP that has already been provided to, and in some cases documented and verified by, other programs. MCC/HFP would not accept less information than what is required for traditional eligibility determination, but would use existing information in order to prevent families from having to complete additional paperwork. This approach is encouraged in guidance from the Federal Health Care Financing Administration (HCFA). Federal policy allows a state's Medicaid program to accept another program's eligibility determination when the other program's eligibility requirement and the methods for determining eligibility are equal to or more restrictive than those of the Medicaid program.

Eight programs in California have income requirements that are compatible with or similar to those of MCC and HFP, though the requirements are not equal to or more restrictive than MCC and HFP in most cases. These programs include Food Stamps, WIC, NSLP, Head Start, Child Care, State Preschool, CHDP and the Child Care Food program.

There are various differences, however, between these programs and MCC/HFP with respect to the methods used for determining income eligibility (i.e. documentation of income, use of income deductions, and definition of household composition). A comparison of eligibility determination methods for these eight programs with those of MCC and HFP reveals that *none* of the programs has eligibility requirements and determination methods which, for every participant, are equal to or more restrictive than those of Medicaid. *Consequently*, the income eligibility information collected by another program would not be sufficient for MCC/HFP to accurately determine whether a child should be enrolled in MCC or HFP. According to Federal requirements, children must be screened and enrolled into MCC, not HFP, if they are eligible for MCC. Furthermore, under current MCC statute and regulations, and HFP regulations, it is not possible for MCC and HFP to accept completely the income eligibility determinations of these other programs. Consequently, one cannot simply deem MCC/HFP full eligibility or income eligibility for children who meet the requirements of these other programs.

An alternative approach would be for MCC and HFP to accept some eligibility information collected and provided by other programs while either, re-determining and assessing other elements under MCC/HFP rules, or collecting information directly from the family by MCC/HFP. Since many other programs currently do not collect citizenship or immigration status information, obtaining this information from the family would be the responsibility of MCC/HFP.

Six of the eight income-tested programs indicate that this option is promising and that it would be possible to obtain informed parental consent to share eligibility information with MCC/HFP. These include Food Stamps, WIC, CHDP, Head Start, Child Care and State Preschool.<sup>10</sup>

Two income- or means-tested programs – NSLP and Child Care Food – indicated that they could not obtain parental consent to share eligibility information. NSLP and Child Care Food oppose *any* sharing of contact and eligibility information for several reasons, which are described in <u>Chapter 5</u> and in the respective program profiles in <u>Appendix E</u>.

Beyond the income-tested programs, it would be possible to implement this option on a limited basis through schools and other programs that may collect some income information from families. These programs include school-based programs such as Healthy Start, local child support agencies, ABC projects, local alcohol and other drug programs, and local mental health departments.

### Option E: **Presumptive Eligibility**

Grant presumptive eligibility for MCC and/or HFP, and thus allow immediate access to services for a limited term, to children who appear to meet the MCC/HFP income requirements or who have already met the requirements of programs with similar income guidelines.

Offering children immediate access to health care during a presumptive eligibility period pending their complete enrollment is permissible under Federal law. Presumptive eligibility currently is implemented in California through the Medi-Cal Presumptive Eligibility for Pregnant Women program.

A few income-tested programs indicate that it would be possible to implement presumptive eligibility through the program. Under Federal law, California could qualify each of the following entities to grant presumptive eligibility. These include Food Stamps, WIC, CHDP, Child Care, State Preschool and Head Start. In the case of Food Stamps, the granting of presumptive eligibility would function more like an "accelerated enrollment," because screening would be conducted by county EWs, who are already using accepted screening logic. In addition, presumptive eligibility could be implemented through the Child Support program; and at schools by school nurses, public health nurses and school-based programs (i.e., Healthy Start and Head Start).

<sup>&</sup>lt;sup>10</sup> Due to the fact that CHDP collects very limited income and family size information, contact and income eligibility information shared with MCC/HFP by CHDP would be treated as a referral for follow-up by MCC/HFP, instead of the basis for initiating an application.

Presumptive eligibility for children could be modeled after the service delivery system operated by the state's Family Planning, Access, Care and Treatment (PACT) program, and implemented through various entities including medical providers, other incometested programs, and at school sites by those knowledgeable about children's health history and financial status. To do so, however, would require addressing multiple implementation challenges including: prevention and monitoring for fraud, the difficulty of tracking multiple episodes of presumptive eligibility, and how to avoid providing presumptive eligibility to children already enrolled in either MCC or HFP and making duplicative payments.

### **Critical Issues for All Programs**

A program-by-program summary of the **most promising options** is provided in <u>Chapter 5</u>. Detailed information about each program is presented in the program profiles in <u>Appendix E</u>.

Implementation of each option would have significant implications both for MCC/HFP and the other programs involved. While each of these other programs expressed interest in coordination with MCC/HFP in some way, they also shared concerns about the impact on their own programs. There are two critical issues to highlight.

First, there would be a significant workload and fiscal impact on certain programs and schools resulting from any efforts to streamline application and enrollment for MCC and HFP. Training and additional resources will be needed given that programs are generally prohibited from using their own program funds for non-program activities, and schools do not have resources for health insurance enrollment efforts.

The second issue is the potential negative impact on the enrollment of other programs and schools if they are to function as a gateway into MCC and HFP. Other programs and schools are regarded as trusted sources of information for all children and families, regardless of citizenship and immigration status. For them to maintain this level of trust, families will need to understand fully the MCC/HFP citizenship and immigration requirements and confidentiality rules. Otherwise, it is possible that some families may be surprised when citizenship and immigration information is requested by MCC/HFP, and feel that the other program has acted inappropriately in sharing the family's contact and/or eligibility information. Both the workload and program integrity issues are described further in <a href="Chapter 4">Chapter 4</a>.

### Purpose and Methodology of the Report

This report was developed in response to AB 2877 (Chapter 93, Statutes of 2000), which required the State Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) to prepare a report on options for streamlining the MCC and HFP eligibility process for children enrolled in, or applying to, other programs with income eligibility guidelines similar to those of MCC and HFP. The rationale was that all programs that have contact with children, youth and families could play a greater role in helping them obtain health insurance for which they are eligible.

Specifically, the legislation states:

"The State Department of Health Services and the Managed Risk Medical Insurance Board shall develop options for implementing streamlined processes for establishing Medi-Cal program and Healthy Families program eligibility, as applicable, for a child enrolled in or applying to certain public programs, such as the School Lunch program, the Food Stamp program, and the California Supplemental Food Program for Women, Infants and Children, or other programs as determined by the department."

This report examines a range of options to streamline MCC and HFP application and enrollment processes for children participating in each of the major programs that provide services to children, youth and families in California. In order to develop this report, the California Health and Human Services Agency (CHHS), DHS and MR MIB led a collaborative effort that included the following departments: California Department of Education (CDE), Department of Social Services (DSS), Department of Child Support Services (DCSS), Department of Mental Health (DMH), Department of Alcohol and Drug Programs (ADP), Employment Development Department (EDD), Department of Development Services (DDS), and the U.S. Department of Health and Human Services.

This is one of the many examples in which CHHS is promoting coordination and services integration among its programs, departments and CDE. Greater coordination and services integration among programs and departments is needed to enable more individuals and families to more easily access the multiple services and supports for which they are eligible.

### Chapter I: Purpose and Methodology of the Report

### **Purpose**

AB 2877 (Chapter 93, Statutes of 2000) requires the State Department of Health Services (DHS) and the Managed Risk Medical Insurance Board (MRMIB) to prepare a report on options for streamlining the Medi-Cal for Children (MCC) and Healthy Families Program (HFP) eligibility process for children enrolled in, or applying to, other programs with income eligibility guidelines similar to those of MCC and HFP.

Specifically, the legislation states:

"The State Department of Health Services and the Managed Risk Medical Insurance Board shall develop options for implementing streamlined processes for establishing Medi-Cal program and Healthy Families program eligibility, as applicable, for a child enrolled in or applying to certain public programs, such as the School Lunch program, the Food Stamp program, and the California Supplemental Food Program for Women, Infants and Children, or other programs as determined by the department."

### Methodology

In response to this requirement, the California Health and Human Services Agency (CHHS), DHS, and MRMIB led a collaborative effort to identify and assess the feasibility and implications of implementing a range of options intended to streamline MCC and HFP application and enrollment processes for children participating in several public programs.

Rather than focus only on those programs with income guidelines similar to MCC and HFP, this effort includes the major programs and departments that provide services to children, youth and families. Thus, the programs featured in the report include both means-tested programs that have income eligibility requirements as well as non-means tested programs that serve individuals and families with a particular need regardless of income. The rationale is that all programs that have contact with children and families may be able to play a greater role in helping them obtain health insurance for which they are eligible. This is one of the many examples in which CHHS promotes coordination and collaboration among its departments and the California Department of Education (CDE) in order to enhance individuals' and families' access to needed services and supports.

As a result, this interagency effort includes DHS and MRMIB, Department of Social Services (DSS), Department of Child Support Services (DCSS), Department of Mental Health (DMH), Department of Alcohol and Drug Programs (ADP), Employment Development Department (EDD), Department of Development Services (DDS), CDE and the U.S. Department of Health and Human Services, Administration for Children and Families (ACF), Region IX.

This project examines the following programs:

### MEANS-TESTED PROGRAMS THAT COLLECT INCOME INFORMATION

- California Work Opportunity and Responsibility to Kids (CalWORKs) Program DSS
- Food Stamps Program DSS
- Supplemental Nutrition Program for Women, Infants and Children (WIC) DHS
- National School Lunch Program (NSLP) CDE
- Child Health and Disability Prevention (CHDP) Program DHS
- Federal Head Start Program U.S. Department of Health and Human Services
- Child Care and State Preschool Programs CDE
- Child Care Food Program (CCFP) CDE

## NON-MEANS-TESTED PROGRAMS, SYSTEMS AND CENTERS THAT PROVIDE SERVICES AND MAY NOT COLLECT INCOME INFORMATION

- DHS' School Health Connections and CDE's Healthy Start, which are schoollinked efforts that promoting student access to services and supports, including health insurance programs
- Child Welfare Services (CWS) DSS
- Foster Care and Adoption Services<sup>11</sup> DSS
- Answers Benefiting Children (ABC) Project DSS
- Developmental Services Regional Centers DDS
- Mental Health Services DMH
- Alcohol and Other Drug (AOD) Programs ADP
- Child Support Program DCSS
- Unemployment Insurance (UI) Program EDD

State-level representatives from each of the above programs participated in an interagency working group and collaborated with CHHS, DHS and MRMIB to examine options for streamlining the MCC/HFP application and enrollment processes through these programs.

CHHS also initiated efforts to obtain input on the options from local programs and stakeholder organizations. The workgroup distributed questionnaires to a sample of

<sup>&</sup>lt;sup>11</sup> Children who enter the Foster Care program without health insurance are automatically eligible for MCC. Thus, there is an existing linkage to MCC for children served through the Foster Care and Adoptions programs. As a result, this report does not present options for creating a new linkage between MCC/HFP and those two programs.

local programs and stakeholder groups in December 2000. Survey responses contributed to the development of this report. These survey responses also provide information for use in discussions about implementation of the options. Limitations on time and resources prevented CHHS from conducting more substantial engagement with local programs and schools. A series of focus groups with local-level representatives could further explore possible implementation issues. This input would be very valuable since successful implementation of the options would depend in part on the ability and commitment of local programs to implement these new strategies. Finally, CHHS, DHS and MRMIB consulted with a group of key advocacy organizations that have been very active in discussions and/or written published reports about possible opportunities relating to Express Lane Eligibility methods.

These activities resulted in analysis of five options for streamlining application and enrollment processes of MCC/HFP through coordination with other programs. These options are the subject of Chapter 3.

### Chapter II: Introduction and Background

### The Need for Health Insurance Coverage

Access to health insurance for pregnant women, infants and children is one of the most important factors in reducing low-weight births and infant mortality, and in ensuring that children get the health care they need to have healthy minds and bodies. Numerous studies show that there are consequences for children not having health insurance. Uninsured children are less likely to receive medical care when sick or injured, to have a regular source of health care, to be fully immunized, to have medical care and well-child visits, and to obtain dental care. In addition, uninsured children are more likely to be sick upon admission to a hospital, to use more resources during hospitalization, and to suffer from higher mortality rates while in the hospital. Notwithstanding the burden on these children and their families, there are costs to the health care system and society as well for providing primary care to the uninsured in hospital emergency rooms.

The consequences for children of not having health insurance are not limited to poor health outcomes. Access to health care is important to children's ability to succeed in school. Research shows that children's early physical and mental health is important to their later readiness for school and school success. Students who frequently are absent for health reasons, or who suffer from health problems, may not perform as well in school. 15

Despite the benefits of health care coverage to both children and society at large, there are a large number of children nationwide that are not covered by any type of health insurance. There are almost 14 million children under 18 nationwide who lack coverage. Most uninsured children live in families with incomes below 200% of the Federal Poverty Level (FPL) and that have at least one working parent. It is estimated that a significant number of these children - about 8 million - are eligible for coverage through the federal Medicaid or State Children's Health Insurance (SCHIP) programs. <sup>17</sup>

The Medicaid program was created in 1965 through Title XIX of the Social Security Act for the purpose of providing health care coverage to poor and low-income children, families and specific individuals that lack health insurance. SCHIP was created in 1997 under Title XXI of the Social Security Act. SCHIP allows states to expand coverage to children either through their existing Medicaid program, or through a separate child insurance program or both. Nationally, we have witnessed a commitment in recent

Condition on admission, resource use, and outcome." *JAMA*, 1991, Jan 16, 265(3): 374-9.

14 Child Trends, "School Readiness: Helping Communities Get Children Ready for School and Schools Ready for Children," August 2000.

All cited in National Maternal and Child Health Policy Consortium, "Facts About Uninsured Children,"
 July 1997.
 Hadley, Steinberg and Feder. "Comparison of uninsured and privately insured hospital patients.

Symons, C.W., et al, "Bridging Student Health Risks and Academic Achievement Through Comprehensive School Health Programs," *Journal of School Health*, August 1997, 67:6, p 220. <sup>16</sup> Mills, R.J. "Health Insurance Coverage," *Current Population Reports*, U.S. Census Bureau, September 2000, p. 60.

The Children's Partnership and the Kaiser Commission on Medicald and the Uninsured, "Putting Express Lane Eligibility Into Practice: A Briefing Book and Guide for Enrolling Uninsured Children Who Receive Other Public Benefits into Medicald and CHIP," November 2000.

years to get eligible children enrolled in the Medicaid and SCHIP programs. States across the country are pursuing a combination of efforts to simplify and streamline application and enrollment procedures, expand programs to cover more children, and develop innovative outreach and education strategies targeting the hardest-to-reach individuals and families.

### Medi-Cal for Children (MCC) and the Healthy Families Program (HFP)

Medi-Cal for Children (MCC) and the Healthy Families Program (HFP) are the two major health coverage programs in California that provide no-cost or low-cost coverage for poor and low-income children. The California Department of Health Services (DHS) administers MCC and offers health coverage for California's low-income and disabled children. The Managed Risk Medical Insurance Board (MRMIB) administers HFP and offers health coverage for children whose family income is too high to qualify for MCC. According to the most recent data available, 2.7 million children, or over one in four children in California, are enrolled in no-cost MCC. Over 400,000 children are enrolled in HFP. Detailed descriptions of both programs are provided in Appendix A and B.

Eligibility for MCC/HFP is based on a child's age, family size and income. Children from birth up to age 19 may qualify for MCC by living in families with incomes below a certain level, or by receiving cash assistance through other public assistance programs. Family income limits vary with the age of the child and range from up to 100% of FPL for adolescents and teens, to up to 200% of FPL for infants. HFP serves children from birth up to age 19 who are not eligible for no-cost MCC, do not have employer-sponsored coverage, and their family income does not exceed 250% of FPL. Both programs base eligibility on net income after granting certain deductions, not gross income. Both programs have similar income deductions.

If a child is determined eligible for no-cost MCC, federal rules predude him/her from enrollment in HFP. If the family's income exceeds eligibility criteria for no-cost MCC and the child qualifies for MCC with a share of cost, the child may still qualify for HFP. For HFP coverage, the family must pay a low-cost monthly premium ranging from \$4 to \$9 a month per child to a maximum of \$27 per month for all children in the family.

To qualify for the full-range of MCC services, a child must be a U.S. citizen, national, or eligible qualified immigrant. Undocumented immigrant children may be eligible to receive MCC benefits for emergency and pregnancy-related services only. To qualify for HFP, a child must be a U.S. citizen, or national or eligible qualified immigrant. As mandated under Federal law, both programs request documentation of immigration status as proof that the child meets the above requirements. HFP also requires proof of citizenship status, which usually is satisfied with a copy of the child's birth certificate.

<sup>19</sup> A federal waiver request to provide coverage to parents under the HFP is pending. If approved, it should add about 290,000 adults to the eligible population of the HFP.

MCC data is from April 2000. HFP data is from April 2001.

<sup>&</sup>lt;sup>18</sup> California chose to implement its SCHIP program through the combined approach by expanding Medi-Cal and establishing a separate children's health insurance program through HFP. HFP was established by Assembly Bill 1126 (Villaraigosa), which passed in October 1997.

### MEDI-CAL FOR CHILDREN (MCC) AND HEALTHY FAMILIES PROGRAM (HFP) TARGET POPULATIONS AND FEDERAL POVERTY LEVEL (FPL) INCOMETHRESHOLDS

Medi-Cal	for Children	Healthy Families Program		
(Children 0-18 and	d Pregnant Women)	(Uninsured Children 0-18 Ineligible for MCC)		
Age of Child	Percent of FPL	Age of Child	Percent of FPL	
0-1	0-200%	0-1	200-250%	
1-5	0-133%	1-5	133-250%	
6-18	0-100%	6-18	100-250%	

County welfare department (CWD) staff performs MCC eligibility determinations. Counties maintain offices and often out-station staff at major hospitals and clinics. Individuals may apply for MCC by mail, or in person. MCC applicants may obtain an application in a variety of ways, including visiting or phoning the CWD, telephoning the MCC/HFP toll-free outreach line, or by picking up an application from the location of a MCC/HFP Certified Application Assistant (CAA) such as a community-based organization, or a clinic or other location where a MCC worker is out-stationed. Applicants complete the forms and return them either to the CWD or to the HFP Single Point of Entry (SPE) administrative vendor. A face-to-face interview is not required to complete the application process. Applicants may return requested verifications with their mail-in applications or may provide them at a face-to-face interview with an eligibility worker (EW). EWs may request additional information or documentation needed to complete eligibility determination. Counties have 45 days to complete this process.

Applicants are notified of the eligibility decision in writing and receive their Medi-Cal card in the mail. If the applicant is a child and is determined to be ineligible for no-cost Medi-Cal, then he or she is evaluated for Medi-Cal with a share of cost. On the Notice of Action that informs the family about the outcome of their review for no-cost Medi-Cal eligibility, some counties provide the HFP toll-free number so that the family can call for information and an application.

Families may also complete the joint MCC/HFP mail-in application and submit it along with the appropriate documentation to the SPE. The application is 4 pages in length, and is available in 11 languages. The SPE screens the applications for no-cost MCC eligibility. Applications that appear to be MCC eligible are sent via overnight mail to the appropriate county Medi-Cal office for an eligibility determination. Applications that appear to be HFP eligible are forwarded to the HFP eligibility determination unit, which is in the same location as the SPE. A complete HFP application is processed within 10 days, while an incomplete application is processed within 20 days by the HFP administrative vendor under contract with MRMIB.

Families who would like assistance in applying for MCC/HFP may receive assistance by calling the MCC/HFP toll-free line (1-800-880-5305), which provides assistance in 10 languages from 8 a.m. to 8 p.m., Monday through Friday. In addition, CAAs, who have

been trained to provide assistance and are affiliated with an Enrollment Entity, can assist applicants.<sup>21</sup>

The Medi-Cal Eligibility Data System (MEDS) stores MCC and HFP eligibility and enrollment data; however, data on the HFP eligibility determination process is on the data system maintained by the HFP administrative vendor. Since every CWD has access to the MEDS system via an interface, it is possible for each county to check MEDS to verify MCC or HFP enrollment for children. Additionally, health care providers can verify Medi-Cal information via Medi-Cal's Point of Service Eligibility System, and HFP information through the child's health or dental plan.

### **Efforts to Improve and Increase Enrollment**

There is much that MCC/HFP have done since the implementation of the HFP in July 1998 to improve the application and enrollment processes and to address other barriers to enrollment. These efforts can be grouped into three major areas: 1) expanded and targeted outreach, assistance and education; 2) program expansions; and 3) simplification and coordination of requirements and processes.

### 1. EXPANDED AND TARGETED OUTREACH, ASSISTANCE AND EDUCATION

California developed a multi-pronged outreach, assistance and education campaign for MCC/HFP to reach more segments of California's large, diverse, multilingual and multicultural population. DHS, in collaboration with MRMIB, directs the campaign. It strategically combines mass media education with community-based outreach to increase public awareness of MCC/HFP and to identify the benefits of enrolling children in health care coverage. The campaign provides information to families in a variety of languages.

The mass-media component of the campaign uses print, television and radio advertising throughout the state. Several corporate sponsors complement the campaign by displaying information about MCC/HFP on their products. The advertisements and corporate sponsorship materials direct people to the toll-free line for more information about MCC/HFP and about where to obtain application assistance. In addition, the campaign directs focused advertising to Latinos, Asian, and African-American communities.

The outreach campaign also has a community-based component, which gives communities flexibility to develop approaches that best meet their own needs.

<sup>&</sup>lt;sup>21</sup> An enrollment entity is an entity that has registered with the State and meets the requirements to receive reimbursement for assisting families in successfully enrolling in MCC or HFP. Examples of an enrollment entity include: a community-based organization, school, dinic, health care provider, insurance agent, WIC site, day care provider, health department, tax preparer, Indian Health Service Facility or other non-profit organization.

This component has four parts:

### 1. Contracts with Local Community-Based Organizations (CBOs):

DHS contracts with CBOs that provide linguistically and culturally appropriate information and services in areas that are heavily frequented by uninsured target populations.

### 2. 1931(b) Outreach Contracts:

DHS allocates federal Medi-Cal Outreach contracts under the 1931(b) program to target to individuals who are no longer eligible for CalWORKs, though they may still be eligible for Medi-Cal.

### 3. Use of Certified Application Assistants (CAAs):

DHS authorizes trained CAAs to help families complete and submit the MCC/HFP application. CAAs receive \$50 per application processed with their assistance for every successful enrollment into MCC or HFP. The State maintains a toll-free help line for CAAs, publishes an informational bulletin for CAAs, conducts CAA training sessions, and provides collateral marketing materials. CAAs assist in preparation of more than 60% of all mail-in applications.

#### 4. School-Based Outreach:

DHS' School Health Connections works with schools and school districts to conduct outreach through the NSLP and other existing school activities. Funding for School Health Connections is primarily from a grant from the Packard Foundation.

These localized strategies supplement the mass media campaign and address barriers to enrollment that are most effectively handled at the community level using entities that families trust. Such efforts help to correct misperceptions about eligibility requirements, confidentiality rules, and the belief that MCC/HFP are welfare programs or are of low quality.

Increased funding is also available to immigrant communities to promote MCC/HFP through culturally sensitive organizations with established links to populations that are uncomfortable using government health programs. Further, the Federal Immigration and Naturalization Service (INS), in May 1999, clarified that receipt of Medi-Cal and the HFP does not have public charge implications. This means that immigrants will not be threatened with deportation or other adverse consequences if they choose to use publicly funded health services.

The FY 2000-01 outreach campaign will focus on implementing aggressive steps to target the hardest-to-reach populations (e.g., families who have not yet received MCC/HFP information, residents of rural or isolated geographic areas, or individuals and families that relocate often). New strategies are under development this year based upon findings of the January 2000 HFP/MCC Public Awareness Survey and on input received from the HFP/Medi-Cal Outreach and Education Advisory Committee.

Some of the suggestions gleaned from these efforts include:

- Increase use of schools and other group settings such as work sites and places of worship for promotion and information about the programs.
- Provide more and better personal assistance for the enrollment process and as a source of general information about the programs and eligibility requirements.
- Increase advertising with ad content that speaks more directly to eligible families.

### 2. Program Expansions

Several expansions of the MCC and HFP programs increased the number of children and adults eligible for the programs. The most recent and most significant expansion of the Medi-Cal program resulted from a change in the income requirements for the 1931(b) program. The intent of the 1931(b) program was to ensure that families that were eligible for Medicaid under the discontinued Aid to Families with Dependent Children (AFDC) program rules could continue Medi-Cal coverage under CalWORKs. In California, Medi-Cal expanded the 1931(b) program to include CalWORKs recipients. Legislative changes effective March 2000 allowed parents in two-parent households who worked 100 hours or more and have an earned income less than 100 percent of FPL to remain eligible for no-cost Medi-Cal. These new changes provide a large expansion of the Medi-Cal program, which will cover approximately 250,000 parents who are currently on Medi-Cal or have only applied for Medi-Cal for their children. Additionally, this expansion covers an unknown number of families who have not applied for Medi-Cal because they did not meet former income requirements. Implementation of this program provides an opportunity to reduce significantly the number of uninsured families.

Another recent program expansion focuses on the foster care population. As of October 2000, children who age out of the foster care system will continue to receive no-cost Medi-Cal until they turn 21. This ensures that this very vulnerable population retains health coverage.

In July and November of 1999, several expansions to the HFP also increased the number of children eligible for that program. These changes included:

- Expanding income eligibility from 200 to 250 percent of FPL. As a result, HFP extended coverage to children from birth to age one, in families with incomes between 200 and 250 percent of FPL. (Children from birth to age one with incomes below 200 percent already were covered by MCC.)
- Authorizing HFP to use MCC income deductions when determining eligibility.
- Providing HFP coverage to qualified immigrants who arrived in the United States after August 22, 1996.
- Allowing emancipated minors to apply for HFP on their own behalf.
- Increasing the claiming period for Child Health and Disability Prevention (CHDP) providers from 30 to 90 days for children who enroll in MCC/HFP.

Currently, the State is pursuing a federal Title XXI SCHIP 1115 demonstration waiver to expand HFP coverage to parents up to 200 percent of FPL. This approach is based on evidence that covering parents encourages families to enroll their children who are eligible.

### 3. SIMPLIFICATION AND COORDINATION OF MCC AND HFP

The MCC/HFP programs also simplified application and enrollment processes, and improved coordination between the two programs.

First, the length of the joint MCC/HFP application was reduced to 4 pages in April 1999. At the same time, the programs reduced the required income documentation. MCC and HFP reduced the number of pay stubs required from those representing a 30-day period to only the most recent pay stub. Like HFP, MCC also started accepting a federal income tax form, instead of pay stubs, as income documentation. These changes significantly reduced the amount of documentation required and simplified the application process.

Second, beginning in January 2001, Medi-Cal children beneficiaries receive continuous eligibility for 12-months. Adult beneficiaries, however, must continue to report within ten days any information that may affect their own eligibility (e.g., changes in income, property, family composition, address, or other health coverage). HFP re-determines eligibility of children every 12 months by mail regardless of changes in family income or composition throughout the year. Under the waiver submitted to the Federal Government to expand HFP to parents, one of the proposals includes allowing 12 months of continuous eligibility for parents in both Medi-Cal and HFP, similar to the process now in place for children in MCC and HFP.

Third, effective January 1, 2001, DHS eliminated the requirement that Medi-Cal recipients had to complete and submit quarterly status reports on their income and family size.

Fourth, DHS and MRMIB have under development a new mail-in application for parents and children to use in applying for Medi-Cal and HFP. Currently, counties accept MCC applications for children by mail, but this new application would allow parents to apply on their own behalf for Medi-Cal and for HFP (under the parent coverage waiver). The new mail-in application will follow the same format and be available in 11 languages like the current joint HFP/MCC application.

Fifth, Medi-Cal and MRMIB have collaborated in the development and current pilot testing of the Health-e-App. Health-e-App is a web-based initiative developed in a public/private partnership between the State of California and the California Health Care Foundation (CHCF). It is an electronic screening and application system for families who want to enroll in the MCC or HFP. Health-e-App presents the current application forms on a computer screen, which is connected to the Internet and electronically transmits the application to SPE for processing.

The Health-e-App is a pilot program in San Diego and may be available statewide in the future. After further development and demonstrated success of its efficiency and user satisfaction, there is great potential to place Health-e-App terminals at various program sites, including WIC sites, child care centers, and schools. The Health-e-App is expected to improve significantly the existing application process by improving:

- User satisfaction, thereby reducing enrollment barriers;
- Accuracy and completeness of application data;
- Efficiencies in the application process;
- Online selection of health providers and plans for HFP; and
- Accountability in tracking application status.

Finally, several coordination and simplification efforts are proposed for HFP and Medi-Cal in the context of the 1115 parent coverage waiver proposal:

- There will be a joint application for all families (eligible for either HFP or Medi-Cal); the application will be sent to the HFP SPE.
- Most of the eligibility rules for families will be identical in the two programs, including the type of income documentation required.
- Families transferring between the programs, in either direction (e.g. from HFP to Medi-Cal, and from Medi-Cal to HFP), will receive bridge coverage for 60 days.
- Families screened at SPE with members split between Medi-Cal and HFP will receive accelerated enrollment in Medi-Cal for those that appear Medi-Cal eligible, while the information is forwarded to the county for final eligibility determination.
- The tracking system through SPE and MEDS for both Medi-Cal and HFP will be improved.
- Application information transfers will occur between HFP and Medi-Cal.
- A county liaison unit at SPE will follow up on application transfers to the counties and assist with coordination between the counties and the HFP administrative vendor on individual applications when necessary.

Currently, options under examination at the California Health and Human Services Agency (CHHS), DHS, and MR MIB would build upon these efforts to further simplify requirements and processes, and improve coordination between the programs. New Federal SCHIP and Medicaid regulations require increased coordination between children's health programs, including requiring Medicaid eligibility agencies to coordinate with SCHIP to enroll children identified at Medicaid sites as being SCHIP eligible. These regulations are under review currently by the new Federal Administration. States must describe the procedures used to accomplish SCHIP coordination with other public and private health insurance programs and the methods used to ensure children are enrolled in the appropriate program for which they are eligible. Specifically, the regulations require that State Medicaid agencies have

procedures to ensure applicants do not provide information or documentation already provided to SCHIP, to determine eligibility in a timely manner, to promptly notify SCHIP when a Medicaid eligibility determination has been made, and to facilitate SCHIP enrollment if the child is not eligible for Medicaid (at initial application and renewal). SCHIP agencies are now required to offer assistance in completing the Medicaid application process. The new regulations also state that when a child is screened as potentially eligible for Medicaid and later found ineligible, SCHIP must determine eligibility without requiring the family to complete a new application. Additional information about these regulations is provided in <a href="mailto:AppendixH">Appendix H</a>.

Other "streamlining options" for Medi-Cal and HFP could include:

- Design and implement a uniform document or standardized worksheet to be attached to NOAs for use by all counties when a family's income increases and the family is moving from a no-share-of-cost Medi-Cal status to a share-of-cost Medi-Cal situation. The document/worksheet would indicate the income and family size determination made by MCC. With a family's permission, a child's income and household information will be directly transmitted from MCC to HFP, instead of requiring the family to complete a new application for HFP. The document/worksheet would be sent to the SPE for transitioning the child(ren) to the HFP. As is the current process, the child(ren) would be given a "bridging month" of no-cost Medi-Cal eligibility, while the HFP enrollment papers are processed.
- Encourage counties to assist families in applying for the HFP when the families are determined to be ineligible for MCC. Ensure the counties understand how to claim administrative support funds for this activity.
- Provide to counties regular trainings and an updated manual on Medicaid that includes information on processes for interaction with HFP.
- Provide to CAAs regular trainings and more efficient tools, such as Health-e-App, to enhance their ability to serve more families, more effectively, in enrolling in MCC or HFP to maintain their health care coverage.
- Collect information from counties, in consultation with a working group composed of county representatives, which can be used to develop measures of effectiveness for the purpose of "benchmarking" best practices.

### **Another Approach: Streamlining Through Other Programs**

Despite all of these efforts, a large number of California's children eligible for MCC/HFP remain uninsured. Precise data on the number of children eligible for MCC/HFP currently is not available. Another new, but promising, approach for enrolling these children is to streamline the application and enrollment processes for children who are applying for, or participating in, other public programs. By establishing new or better connections between MCC, HFP and other public programs, we can find and more quickly enroll uninsured children in the health insurance programs. "Express Lane Eligibility" is the name often given to such approaches because, like the express lane in the supermarket or on the highway, the goal is to expedite service.

This approach makes sense considering that many uninsured children in California are eligible for, and perhaps already participating in, these other public programs. Two reports shed light on this issue.

First, the Urban Institute analyzed data from their 1996-97 National Survey of America's Families (NSAF) and found that about 60 percent of all low-income, uninsured children nationally live in families that participate in the NSLP, WIC, Food Stamps or Unemployment Compensation programs. According to the same report, more than four of five uninsured children in California participate in one of those programs. This was the highest rate in the nation, followed by Mississippi and Alabama at 79% and Texas at 74%. <sup>23</sup>

In another recent report, it was estimated that over 700,000 uninsured children in California potentially are eligible for MCC/HFP and enrolled in at least one of the following programs: Food Stamps, WIC, or NSLP.<sup>24</sup> This report adjusted the Urban Institute 1996-97 NSAF data based on other known data (e.g., immigration status, income and age of uninsured children and characteristics of program enrollees) to get a more accurate estimate.

Unfortunately, administrative data maintained at the State level cannot yield actual numbers of uninsured children who are enrolled in other public programs. It is possible for a few of these programs, however, to identify the number of children who are currently enrolled in MCC or HFP. State administrative data for Food Stamps confirm that there are about 46,000 children receiving non-assistance Food Stamps (i.e., not in CalWORKs) who are not enrolled in either MCC or HFP, although they are very likely to be eligible for one of the programs. Administrative data also show that about 285,000 children participating in WIC are not enrolled in MCC. To complete this picture, a data match is underway to determine how many of these non-MCC children in WIC are enrolled in HFP.

A range of potential methods exists for streamlining application and enrollment for MCC and HFP through coordination with other programs. The most effective streamlining methods relieve families from having to provide the same contact, income and other eligibility information more than once, thereby removing the duplicative provision and verification of information. Since MCC and HFP are means-tested programs that require families to provide income information, the most promising strategies are those that could be implemented through other programs with compatible or similar income reporting and verification requirements, such as Food Stamps, WIC, NSLP, Head Start, Child Care, State Preschool, Child Care Food, and CHDP.

<sup>22</sup> Kenney, Haley and Ullman. 'Most Uninsured Children Are in Families Served by Government Programs," Urban Institute, December 1999.

<sup>23</sup> Čited in "Putting Express Lane Eligibility into Practice," a publication of The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured, November 2000, p. 7.

<sup>24 &</sup>quot;Express Lane Eligibility: How California Can Enroll Large Numbers of Uninsured Children in Medi-Cal and Healthy Families," A Publication of the 100% Campaign (a collaborative effort of Children Now, Children's Defense Fund, and the Children's Partnership), February 2000, pp. 2-3.

Linking different programs to streamline application and enrollment processes is not new. For example, under Federal law, WIC accepts an applicant's documented participation in Medicaid, Food Stamps, and Temporary Assistance for Needy Families (TANF) as evidence of income eligibility for WIC. The NSLP gives automatic eligibility to children receiving Food Stamps, Food Distribution Program on Indian Reservations (FDPIR), and TANF. In addition, many school districts in California use a method called direct certification to more quickly identify and enroll children in the NSLP if they already receive Food Stamps, CalWORKs and FDPIR.

According to the National Governors Association (NGA), five states (Florida, Massachusetts, Ohio, Pennsylvania, and Washington) received federal grants from the Federal Health Care Financing Administration (HCFA) to experiment with various streamlining and/or simplification methods. One experiment, underway in three states (Massachusetts, Ohio and Pennsylvania), tests self-declaration of income at application and/or annual re-determination. Another experiment in Florida pilots an electronic health coverage application process available at selected day care centers. A third test in Washington looks at coordinating its Medicaid and NSLP to identify quickly and enroll uninsured children. Further description of these experiments is in Appendix F. In addition to these efforts, a few other states have implemented a presumptive eligibility effort through their Medicaid and/or SCHIP program. Appendix G describes these efforts.

As these descriptions illustrate, some states focus on making improvements in one or a few targeted areas. No state has taken a comprehensive approach to streamlining health insurance enrollment by focusing efforts through multiple other programs. California has the opportunity to design and test some innovative strategies that range across a number of programs.

# Chapter III: Options and Implications for Implementation and Enrollment

As indicated in the last chapter, the interdepartmental workgroup identified five options. This chapter presents a general description of each of the five options. The descriptions provide an overview of how each option could be implemented through any one of the programs. The specifics of implementation will vary by program. Examples of how some of these options are being implemented currently in select counties and sites of various programs and schools are provided at the end of each program profile in Appendix E.

### Option A: Referrals with Follow-up Capability

Establish and enhance referral processes between other programs and schools, and MCC/HFP. Ideally, a referral would provide MCC/HFP and/or community-based enrollment entities or certified application assistants (CAAs) with contact information for families so that appropriate follow-up activities can occur.

Many Federal and State programs encourage, and in some cases require, local program sites to conduct referrals to MCC/HFP as part of a larger effort to help children and families access other services that will meet their needs. Programs that *require* referrals to MCC/HFP include: WIC, Child Care, State Preschool, and CHDP (for programs). Programs that *encourage* MCC/HFP referrals include: Food Stamps, CHDP (for providers), Head Start, Healthy Start, and ABC projects. In addition, some schools provide MCC/HFP referrals, often targeted to children served in the NSLP, with assistance from community-based organizations and school-based programs such as Healthy Start and Head Start. Most referrals include inquiring about children's and families' health insurance status, informing and educating families about MCC/HFP and the benefits of health care coverage, disseminating application materials, and informing families of how to contact CAAs in their area.

These referrals could both be expanded to more programs and local program sites, and enhanced to be more effective. First, referrals could be conducted on a regular basis through *all local sites* of programs that currently encourage referrals, as well as other programs that have not yet encouraged referrals on a large-scale basis (i.e., Child Support, Child Care Food, Alcohol and Other Drug Programs, Mental Health Services, Developmental Services Regional Centers, Child Welfare Services, and Unemployment Insurance). In addition, more school districts and schools could conduct referrals with assistance from school-based programs and community-based partners.

Second, the referral approach could be more effective if it included the collection of family contact information so that MCC/HFP, community-based enrollment entities and/or CAAs could follow up with families to complete enrollment. Often, families need multiple contacts with MCC/HFP for them to complete the application and enrollment processes. Programs and schools could obtain parental consent to share a family's contact information with MCC/HFP or a local CAA. To facilitate this process, MCC/HFP would work with programs to develop a new form, or modify existing forms, so that parents would have an opportunity to grant consent for the release of their contact

information to MCC/HFP. Another approach would be for MCC/HFP to create a standard referral process whereby all programs and schools could distribute an official MCC/HFP referral form. Parents would complete and return the form to the program or school, or mail it in a pre-paid postage envelope to another location, to request a MCC/HFP application and assistance. The forms would be forwarded to the appropriate entities (i.e., MCC/HFP, community-based enrollment entities or CAAs) for follow up with families. Some schools and school districts have partnered with community-based organizations and county Medi-Cal offices to use this approach. Examples are provided in the School Health Connections profile in Appendix E.

Fifteen programs indicate that it would be possible to create or enhance an existing referral mechanism (that would include a capacity for follow-up) between their programs and MCC/HFP. These programs include: Food Stamps, CHDP, WIC, NSLP, Child Care, State Preschool, Child Care Food, Head Start, Child Support, Developmental Services Regional Centers, Mental Health Services, Alcohol and Other Drug Programs, Child Welfare Services, ABC Projects, and Unemployment Insurance. Four of these programs (NSLP, Child Care, State Preschool and Child Care Food) express a strong preference for having families complete a new, separate referral form, rather than revise their existing application forms to enable parents to grant consent for the release of their contact information. Finally, for school districts and schools, a referral process is a promising option whether or not the referral is connected to the NSLP. Community-based organizations and school-based programs such as Healthy Start and Head Start could assist with such referral activities.

### Implications for Implementation and Enrollment

- Using referrals is a targeted approach to reach families where there is contact with children who are likely eligible for MCC/HFP.
- Referrals from trusted sources may provide more encouragement to families to complete the MCC/HFP application.
- Entities that currently assist families with application and enrollment into MCC and HFP indicate that it often is necessary to follow up with families multiple times before the process is complete. MCC/HFP can assist with this follow-up if they have family contact information.
- Since applicants have responsibility for submitting applications, there are no complications about confidentiality and information sharing across programs.
- Without further assistance from the referral, families may not complete the application. MCC/HFP may be able to provide assistance in completing the application over the phone, or may be able to refer a family to an out-stationed eligibility worker or CAA for assistance. Assistance, however, may not be provided at the location of the other program, as is proposed under Option B.
- Programs and schools need staff time, training, and resources to identify
  uninsured children, learn about MCC/HFP, maintain a supply of applications or
  referral forms, distribute and collect applications or forms, educate families about
  the programs, obtain parental consent to share contact information with
  MCC/HFP and transmit the information. The MCC/HFP outreach campaign

would need to develop collateral materials, conduct additional training about MCC/HFP for these programs, and develop the capacity to refer a larger number of applicants to CAAs for follow-up and application assistance.

### Option B: On-site Application Assistance

Provide education and on-site application assistance for MCC/HFP at the other program and school locations.

Under this option, families would receive information and assistance in completing and submitting the joint MCC/HFP application on-site at the other programs. Notwithstanding recent efforts to simplify MCC/HFP application forms to make them more user friendly, understanding the health care system and the information required for enrollment can often be intimidating. As a result, people may fail to complete the application unless someone knowledgeable about the program is available to provide information and assistance, much like taxpayers who often need assistance preparing their income tax returns.

Staff of the other program could provide this information and assistance. Alternatively or in addition, a local CAA or an out-stationed Medi-Cal EWs could be present on site, part- or full-time. Some counties already use out-stationed EWs at schools, hospitals, WIC offices and other local sites of programs. Using program staff rather than an outstationed EW or CAA will vary by program, based on its space, resources, and needs governing staff time. Some schools and other programs may be hesitant to invite CAAs onsite unless they are well acquainted with the entity sponsoring the CAA. CAAs may be affiliated with an insurance agent, health care provider, institution, or clinic, tax preparer, a city or county health department, an Indian Health Service Facility, a school, a faith-based organization, a licensed day-care provider, WIC, a Parent Teacher Organization, or other organization that meets the established criteria. CAAs may not be available to provide on-site application assistance at another program on a regular basis, depending on their funding and their organization's other activities and priorities. An advantage of using EWs is that they can determine MCC eligibility and enroll children in MCC. Some EWs also can assist a family in applying for Food Stamps or CalWORKs in addition to MCC.

A promising approach for providing on-site application assistance would be to implement the Health-e-App and related personal assistance at a wide range of program locations statewide. As discussed in <a href="Chapter 2">Chapter 2</a>, the Health-e-App is a webbased screening and application system that electronically transmits MCC/HFP applications to SPE for processing.

Twelve programs indicate that it would be possible to provide on-site assistance at their local sites. These programs include: Food Stamps, WIC, CHDP, Head Start, Child Care Food, Child Care, State Preschool, Child Support, Alcohol and Other Drug Programs, Mental Health Services, Developmental Services Regional Centers, and ABC projects. In addition, it would be possible to provide on-site assistance at schools with assistance from community-based organizations or school-based programs such as Healthy Start and Head Start, or through outreach contracts proposed as part of the 2001-2002 MCC/HFP outreach campaign. Under the \$6 million in funding allocated as part of the

MCC/HFP outreach campaign, these contracts would be available to schools and community-based organizations that work directly with a school.

### Implications for Implementation and Enrollment

- Option B builds on established MCC/HFP practices. Some CAAs or outreach contract recipients already may provide application assistance at various locations. Clinics and health departments often have their own CAAs to assist applicants.
- Option B may reduce the time an applicant spends filling out the application.
- Option B may increase the willingness of applicants to complete the application.
- Staff time, training, and resources will be required by programs and schools to identify uninsured children, learn about MCC/HFP, maintain a supply of applications, educate families about the programs, assist with the applications and forward them to MCC/HFP. The MCC/HFP outreach campaign would need to develop collateral materials and conduct additional training for these programs about MCC/HFP.
- Some programs and schools would not implement this option if their own staff must ask questions pertaining to citizenship and immigration status.
- Use of CAAs or EWs rather than program staff to provide assistance on site may require fewer resources on the part of the program.
- There is potential for Health-e-App terminals to be placed at various program and school sites statewide.

### Option C: Common Application

Use a common application to collect income and other eligibility information simultaneously for MCC, HFP, and other programs.

Common applications allow for the implementation of a "no-wrong-door model" whereby individuals and families can apply for multiple programs at any program site. A common application for multiple programs could be paper-based or automated.<sup>25</sup>

Simplicity and length are key considerations in the development of a common paper-based application. Each program has specific, and often unique, information that must be collected for eligibility determination. Consolidation of multiple applications into one form must include an effort to remove duplicative questions and standardize eligibility requirements; otherwise the application could become very complex and cumbersome for applicants.

At this time, a common paper application is not feasible for most programs due to several reasons. Several programs (NSLP, Child Care, State Preschool, Head Start,

<sup>&</sup>lt;sup>25</sup> In the absence of a common application, some counties have developed a uniform screening form, which is used by multiple programs to conduct appropriate needs assessments and referrals. Like a common application, it helps ensure that children are linked to all necessary services and supports.

and ABC projects) give local sites discretion to design their own application forms. Other programs (CHDP, Child Support, Mental Health Services, Alcohol and Other Drug Programs, Child Welfare Services, and Unemployment Insurance), either do not enroll individuals using a process like that used by MCC/HFP, or use a variety of intake methods or forms. A common paper application could be used with the Food Stamps and Child Care Food programs.

The development of a common automated application could be explored further with a core group of programs that have automated systems such as CalWORKs, Food Stamps and WIC. One challenge for CalWORKs and Food Stamps is that counties administer these programs using one of four automated systems, which are not linked statewide. At this time, the WIC program is the only program that has a common statewide, automated system that could be linked to other programs.

One alternative could be to build on the Health-e-App system to create a common automated application for MCC, HFP, and other programs. While Health-e-App is a promising model for MCC and HFP, further research and evaluation would be needed to determine how other programs could be added.

### Implications for Implementation and Enrollment

- Individuals and families would have improved knowledge of, and access to, multiple programs for which they may be eligible.
- An applicant would experience one-stop program enrollment by providing the same information once when applying for multiple programs.
- An applicant could indicate on the common application whether he/she wants to share information with a particular program, which would reduce confidentiality concerns.
- Use of a common automated application with one-time input of demographic data (i.e., age, income, etc.) would enhance greatly information processing.
   Administrative costs in the long run would be reduced by increased efficiency, time saved, and improved data quality.
- Use of a common automated application could stimulate programs to move to an
  electronic processing environment more quickly as they discover the benefits of
  linking with other programs in a more efficient and effective manner.
- For programs that use an automated system, a common paper application would be a step backwards.
- Due to the specificity of the information needed by each program, it is likely that a common application would be longer than the current four-page MCC/HFP application.
- Other programs that do not collect citizenship and immigration information may not want to develop and use a common application that requests such

<sup>&</sup>lt;sup>26</sup> Currently, a common paper-based application is used for CalWORKs, Food Stamps and Medi-Cal. In addition, MCC and HFP use a joint application.

- information for MCC/HFP, due to concerns that it may discourage families from applying to their own programs.
- Integration of disparate data systems to develop a common automated system would have substantial fiscal impact in the short-term, despite having the potential to achieve long-term cost savings.

### Option D: Sharing Eligibility Information

Other programs with income requirements similar to those of MCC/HFP could obtain parental consent to share with MCC/HFP the income and other eligibility information families have already provided to those programs. MCC/HFP would use this information to initiate the MCC/HFP application process. MCC/HFP would obtain from the family only the additional information needed to complete enrollment. Other programs would not collect any additional information required from MCC/HFP, such as citizenship or immigration status. Obtaining such information from families for eligibility determination would be the responsibility of MCC/HFP.

MCC/HFP would use a child's income and other eligibility information gathered and shared by another program with similar income requirements to initiate a MCC/HFP application. Eight programs have income requirements that are compatible with MCC/HFP. These include: Food Stamps, WIC, NSLP, Child Care, State Preschool, Head Start, CHDP, and Child Care Food.<sup>27</sup>

MCC/HFP would accept the income information that is provided by other programs and then apply any necessary income deductions and assess other eligibility criteria. MCC/HFP would not accept less information than what is required for traditional eligibility determination, but would use existing information in order to prevent families from having to supply duplicative information. This approach offers true streamlining, by removing a burdensome paperwork requirement from families seeking health coverage for their children.

This approach is encouraged under Federal policy. Guidance issued by the Health Care Financing Administration (HCFA) on April 7, 2000 indicates that a state can accept another public program's specific eligibility determination in determining Medicaid eligibility if the other program's eligibility requirement is equal to or more restrictive than Medicaid's.

HCFA provided clarification on this letter in a subsequent Question and Answer (Q&A) document that stated:

<sup>&</sup>lt;sup>27</sup> Washington State is making efforts to strengthen coordination and sharing of information between its Medicaid and National School Lunch programs. The State will pilot a new School Lunch application featuring an "opt-out" box for parents to check if they do not want contact and eligibility information shared with Medicaid. Unless a parent checks this box, information will be forwarded to Medicaid for follow-up and enrollment. The pilot will also attempt to cross-match school lunch data files with Medicaid eligibility files to identify children who are already enrolled in Medicaid. Washington does not have the same concerns about the opt-out option as CDE (e.g., lack of informed consent, confidentiality, etc.).

"When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement...[For example] ...if the resource standard and method for determining countable assets... were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept...[that] determination...without any further assessment on its own part regarding this requirement."

This language indicates that both the specific eligibility requirements of another program and its method of determining these requirements would need to be the same or more restrictive than Medicaid's in order for the other program's determination to be accepted for establishing Medicaid eligibility. While HCFA guidance on this issue does not specifically address SCHIP, the coordination needs between MCC/HFP would require HFP to adhere to MCC requirements.

As was stated, there are eight programs – Food Stamps, WIC, NSLP, Child Care, State Preschool, Head Start, Child Care Food and CHDP – that have income requirements that are compatible with MCC/HFP. In fact, the majority of children participating in any one of these programs are very likely income eligible for either MCC or HFP.

There are differences, however, between these programs and MCC/HFP in terms of the methods that are used for determining eligibility. <u>Table 1</u>, on Page 41, compares the eligibility requirements and determination methods for MCC/HFP and the other programs, and illustrates the complexity of the differences between them. The most significant differences include:

- MCC/HFP calculate net income after certain deductions; many other programs use gross income.
- The definition of "family household" used by MCC/HFP to calculate income may be different than that used by other programs (i.e., parenting status and family relationships may be considered differently).
- Other programs may count income that MCC/HFP do not, or conversely, ignore income that MCC/HFP would consider. For example, WIC counts public assistance payments when establishing income eligibility, while MCC/HFP do not.
- MCC/HFP requires documentation of income, as specified in the State's MCC statute and regulations, HFP regulations, and MCC/HFP State plans that are approved by HCFA. Some of the other programs allow applicants to self-declare their income. Self-declaration of income is used in NSLP, Child Care, State Preschool, Child Care Food, and CHDP. Documentation of income is required for CalWORKs, Food Stamps, WIC and Head Start.

A comparison of the eligibility determination methods of these eight programs with those of MCC and HFP reveals that *none* of the programs has income eligibility requirements and determination methods or complete eligibility requirements and determination methods that, *for every participant*, are equal to or more restrictive than those of

Medicaid. The Food Stamps program is closest to meeting this standard, but Food Stamps uses a different definition of "household" to calculate income and applies different income deductions than those used by MCC/HFP.

Consequently, the income information collected by one of these other programs would not be sufficient in order for MCC/HFP to accurately determine whether a child should be enrolled into MCC or HFP. According to Federal requirements, children must be screened and enrolled into MCC, not HFP, if they are eligible for MCC. Furthermore, under current MCC statute and regulations and HFP regulations, it is not possible for MCC and HFP to completely accept the income eligibility determinations of these other programs, and thus, deem MCC/HFP full eligibility or income eligibility for children who meet the requirements of these other programs.

Federal flexibility and modifications in State policy would be needed to permit deeming of MCC/HFP eligibility for participants of other programs. The changes required for a deeming approach vary by the program from which children would be deemed (i.e., Food Stamps, WIC, NSLP, etc.). Deeming of eligibility is described further in <a href="Appendix">Appendix I</a>. Furthermore, MCC and HFP would need to submit State Plan amendments to HCFA detailing the proposed changes to MCC and HFP for their review and approval.

An alternative to deeming would be for MCC/HFP to use some of the income and other eligibility information provided by these programs to initiate the application process for MCC/HFP. Information received from those programs would require recalibration and assessment under MCC/HFP rules. While the burden of providing information is lifted from the applicant under this option, the eligibility determination process will become more complicated for MCC/HFP staff.

There are several steps involved in the implementation of this option that will have a workload and fiscal impact on other programs and MCC/HFP. First, staff of another program would inquire with a family about whether the child was enrolled in MCC or HFP, or covered by private insurance. If staff primarily contact families through program material rather than personal contact, the program materials could be modified to request information about insurance status. In some cases, it would be possible for the program to check the Medi-Cal Eligibility Data System (MEDS) to confirm the family's report of MCC/HFP enrollment.

Staff would then inform the family of an uninsured child about the child's likely income eligibility for MCC or HFP, and obtain the family's consent to share its income and other eligibility information directly with MCC/HFP. This consent could be obtained as part of the program's initial application and intake process. CHHS, DHS, and MRMIB could work with other programs to develop a consent form or develop some simple statements and questions about consent to add to the program's existing application forms or process. For families already enrolled in the program, permission could be sought during a re-determination visit. Another option is for the program to send existing participants a pre-paid postage postcard to inform them that their children are very likely income eligible for MCC or HFP. Families could check a box on the postcard and return it to grant consent to have their income and other relevant eligibility information shared with MCC/HFP. However, MCC/HFP may need to contact the family

to obtain more recent information depending on when the family last provided their eligibility information to the other program.

Six of the eight income-tested programs indicate that this option is promising, and it would be possible to obtain informed parental consent to share eligibility information with MCC/HFP. These include Food Stamps, WIC, CHDP, Head Start, Child Care and State Preschool. In the case of CHDP, contact and eligibility information shared would be treated as a referral, due to the fact that the income and family size information collected would not be enough to initiate a MCC/HFP application.

The two exceptions are the NSLP and the Child Care Food programs, which oppose any sharing of contact and eligibility information with MCC/HFP for several reasons. According to CDE, the chief reason for the NSLP position is that the California Education Code restricts the NSLP from any sharing participant contact or eligibility information.<sup>28</sup> Further information about the positions taken by the NSLP and Child Care Food program is provided both in <a href="Chapter 5">Chapter 5</a> and in the respective program profiles in Appendix E.

For those programs that do share eligibility information with MCC/HFP, the sharing of eligibility information across programs would require the development of interagency agreements between DHS (MCC) and MRMIB (HFP) and the relevant agencies and programs at the State level. These agreements would clearly specify the appropriate uses of the information.

Programs would transmit eligibility information pertaining to income, allowable income deductions and/or citizenship and immigration status to Single Point of Entry (SPE) electronically, by fax, or by mail. SPE screeners would use this information to initiate a joint MCC/HFP application, completing the four-page application document, with as much information as possible, on behalf of the child. The date the information from a program is received at SPE would establish the date of MCC/HFP application and the beginning date of aid for MCC after a child is determined eligible.

Using the income information provided, SPE would determine if the child appeared to be eligible for MCC or HFP. Information received from a program regarding income deductions could be considered in this screening. Applications that appeared to be MCC eligible would be sent via overnight mail to the appropriate county Medi-Cal office for an eligibility determination. Applications that appeared to be HFP eligible would be forwarded to the HFP eligibility determination unit, which is at the same location as the

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 $<sup>^{28}</sup>$  CDE provided several additional reasons for the positions shared by NSLP and the Child Care Food program. First, it would be time consuming for local agencies and schools to obtain parental consent to share contact and eligibility information. There would also be a workload impact on agencies and schools to direct parents to MCC/HFP if parents ask them additional questions about health insurance enrollment instead of calling the MCC/HFP toll-free line. Second, notwithstanding intensive efforts by staff and/or written materials to explain the implications of sharing information with MCC/HFP, some families are likely to grant consent without fully understanding the implications. Third, some families might choose not to participate in the NSLP and Child Care Food programs if they fear that program participation will have negative consequences pertaining to their citizenship and immigration status. Finally, they are concerned that the confidentiality provisions maintained by MCC/HFP may be breached, which could expose their local agencies and schools to legal risks and jeopardize children's enrollment in those programs.

SPE. Counties and the HFP eligibility determination unit would be instructed to accept the income information provided by the other program and documented on the application/transmittal by SPE to the extent possible and not require applicants to provide duplicative information. Counties and the HFP eligibility determination unit would be responsible for contacting families and obtaining any additional information needed to make an eligibility determination.

Since a few of the programs do not require applicants to provide documentation of income, MCC/HFP would need to collect this information from families as part of the follow-up process. California State Medi-Cal law and regulations and HFP regulations require that MCC/HFP applicants provide documentation of their household income such as a copy of a pay stub or a Social Security Administration award letter prior to a determination of eligibility.

An alternative approach would be for MCC/HFP to accept income information from other programs that is self-declared by an applicant and not require further documentation. There is federal flexibility on the issue of income documentation. Federal law gives state Medicaid and SCHIP programs the option of whether to allow self-declaration of income. Currently, 12 other states (Alabama, Arkansas, Florida, Georgia, Idaho, Kentucky, Maryland, Michigan, Oklahoma, Vermont, Washington, and Wyoming) allow self-declaration of income for their Medicaid and /or SCHIP programs.

A few other states (Massachusetts, Ohio and Pennsylvania) recently received federal grants to pilot self-declaration of income. States that allow self-declaration of income are required to take steps to ensure program integrity. First, applicants that self-declare income would be required to complete affidavits or signed certification, subject to penalties. Second, post-enrollment verification is required under Federal law. Post-enrollment income verification usually is obtained through the Income Eligibility and Verification System (IEVS). However, the information in IEVS may differ from self-declared income depending on whether the applicant's income has changed within the last 6-9 months since data from IEVS is typically 2-3 quarters behind. HCFA encourages states to conduct sample audits after eligibility has been established for income that cannot be checked through IEVS.

HCFA has encouraged states to simplify enrollment processes and indicated that such simplification can be pursued simultaneously with quality control measures to ensure program integrity. HCFA State Medicaid Directors' Letter of January 19, 2001 addresses states' fears that streamlining Medicaid enrollment may compromise program integrity and lead to a higher error rate and potential federal disallowances. It states that denying eligibility to people due to burdensome and complicated application requirements is just as unacceptable as enrollment of individuals who are not eligible.

<sup>&</sup>lt;sup>29</sup> Massachusetts is simplifying the re-determination process to ensure continuous enrollment for eligible children. Families will be allowed to self-dedare their income at re-determination, and the pilot will assess the fiscal impact as well as impact on retention rates and continuity of care. Ohio will pilot self-dedaration of income at initial application and re-determination in a specified geographic area. The pilot will examine the impact of not requiring income documentation on families' perceptions of the application process and also evaluate the prevalence of misreporting of income. Pennsylvania is piloting various types of intensive outreach efforts in a school-based setting. One of the efforts is centered on allowing applicants to self-dedare their income. The evaluation will identify the initial and long-term impacts of this practice.

This letter emphasizes that simplified enrollment processes and quality control measures are not mutually exclusive. This letter also mentions HCFA encouragement for states to do quality control pilot projects.

DHS contacted the 12 states that allow self-declaration of income for information about their efforts. A description of efforts in select states is in Appendix F. None of these 12 states reported problems or increased error rates with self-declaration of income. Several of these states are implementing quality control pilot projects.<sup>30</sup>

In summary, six of the eight income programs with similar income requirements to MCC/HFP indicate that this option is promising. These include Food Stamps, WIC, CHDP, Child Care, State Preschool and Head Start. Beyond these income-tested programs, it would be possible to implement this option on a limited basis through schools and other programs that may collect some income information from families. These programs include school-based programs such as Healthy Start, local child support agencies, ABC projects, alcohol and other drug programs, and local mental health departments.

# Implications for Implementation and Enrollment

- Applicants who have already provided similar income information to another program would not have to provide this information again for MCC/HFP.
   However, applicants would need to provide any information needed for MCC/HFP enrollment that is not collected by the other program.
- Option D may reduce the time and effort it takes an applicant to apply for MCC/HFP.
- This approach would require extensive coordination between MCC/HFP and the identified programs to develop processes for transmission and acceptance of information.
- This approach would require significant additional resources at SPE to complete applications on behalf of children whose information is shared by other programs.

<sup>30</sup> Kentucky is evaluating program integrity as part of a HCFA Medicaid Eligibility Quality Control (MEQC)

Case managers have the authority to accept a verbal explanation or request proof of income. Supervisory-level case review and state-level quality control reviews are used to validate the self-dedared information.

pilot project in their first year of allowing applicants to self-dedare their incomes. A study involving beneficiaries, caseworkers, and employers is being conducted to evaluate the impact of self-dedaration. The results of this study will help Kentucky determine how to proceed with income self-dedaration. Florida's SCHIP program conducts sample audits to verify self-dedared income, and runs self-dedared income against labor records. Maryland runs self-dedared income against statewide public assistance records on the state's automated wage database. Applicants who self-dedare information that conflicts with information on the state databases are contacted by case managers to resolve the discrepancy.

## Option E: Presumptive Eligibility

Grant presumptive eligibility for MCC and/or HFP, and thus allow immediate access to services for a limited term, to children who appear to meet the MCC/HFP income requirements or who have already met the requirements of programs with similar income guidelines.

Offering children immediate access to health care pending their enrollment in MCC/HFP is an option with multiple implementation challenges. This option could be implemented through various entities including medical providers, means-tested programs such as Food Stamps, WIC and Head Start, local child support agencies, and through school nurses or public health nurses located at some school sites.

A qualified entity such as a Medi-Cal health care provider, hospital, local health department, or community health clinic could grant presumptive eligibility to a child whose family income appears to meet the MCC or HFP income requirements. Family income would be self-declared, and the presumptive eligibility determination would be based on gross income. Therefore, providers would not have to determine or apply income deductions. It is possible that upon complete eligibility determination by MCC/HFP some of these children will not be eligible. In this case, neither the family nor the entity granting presumptive eligibility would be financially responsible for medical services received by the child during the presumptive eligibility period. MCC/HFP would be able to claim the appropriate federal matching funds for these children although they are ultimately ineligible.

Federal law gives states the authority to make medical assistance available to a child during a presumptive eligibility period.<sup>31</sup> Guidance from HCFA to State Health Officials in a January 23, 1998 letter indicates that states could grant presumptive eligibility through their Medicaid program or separate state SCHIP program. New SCHIP regulations were developed as a result of recent legislation (BIPA, 2000), which formally extended states' authority to do presumptive eligibility in SCHIP. SCHIP regulations now mandate that the presumptive eligibility period does not exceed 60 days.

California would place all children who appear to be income-eligible for MCC or HFP into fee-for-service Medi-Cal. Once these children completed enrollment in MCC or HFP, then the proper federal match could be claimed.

Means-tested programs could also determine presumptive eligibility for children. A Head Start center, WIC site, or other program with similar income requirements to MCC or HFP could grant presumptive eligibility based upon the income calculated as part of that particular program's eligibility determination. That income would be compared to the MCC/HFP income levels for the presumptive eligibility screening.<sup>32</sup> In addition, local

<sup>32</sup> Another option would be to require this other program to conduct the presumptive eligibility determination based on the MCC/HFP income requirements, rather than its own requirements when they differ; however, the process would likely be difficult and time-consuming for these programs. Consequently, few programs would actually conduct a presumptive eligibility screening. This is a lesson learned from other states.

<sup>&</sup>lt;sup>31</sup> The Balanced Budget Act (BBA) of 1997 (H.R. 2015) and The Medicare, Medicaid and SCHIP Benefits and Improvement Act (BIPA) of 2000 (H.R. 5661, Section 708).

child support agencies could grant presumptive eligibility based on income information collected for one or both of the parents. Another possibility is for school nurses or public health nurses stationed at school sites to grant presumptive eligibility. However, it would be very difficult for any of these entities to make an accurate determination of which health coverage program to grant presumptive eligibility. A way to deal with this issue would be for these entities to grant presumptive eligibility for fee-for-service MCC only. Once these children completed enrollment in MCC or HFP, than the proper federal match could be claimed.

Entities that grant presumptive eligibility would have a specified period of time in which to notify MCC/HFP that this presumptive eligibility determination has been made, and transmit the child's contact and income information. MCC/HFP would follow up with the family to complete the enrollment process. As required by Federal law, the entity granting presumptive eligibility would give the family an application (either the full joint MCC/HFP application or a shorter, modified form with any remaining questions that have not been addressed), and information that will assist the family in completing the application. The program would also explain that the family is being given a presumptive eligibility period for a short period of time in which to complete the enrollment process.

States are permitted to grant presumptive eligibility for a period of no more than two months for children who meet the applicable income level of eligibility. If the process is not completed during this period, the child will lose access to services. Federal law does not limit the number of times that a child can be granted presumptive eligibility within a certain time frame. HCFA has stated, however, that it does not appear reasonable to allow an unlimited number of presumptive eligibility periods for a single child, since this could practically result in continuous eligibility for a person who is actually ineligible.

States have broad discretion to determine the qualified entities that could grant presumptive eligibility. Federal law specifies the qualified entities that a state may choose. These include: TANF offices, Medicaid providers, Head Start programs, WIC agencies, Child Care and Development Block Grant recipients, elementary and secondary schools, state child support enforcement agencies, child care resource and referral agencies, organizations providing emergency food and shelter under the McKinney Homeless Assistance Act, any public or assisted housing program, and any other entities determined by the state as approved by the Secretary of the U.S. Department of Health and Human Services.

Another approach to presumptive eligibility would be to see it as an opportunity to enroll children in MCC/HFP and delay the documentation requirements. Families could provide documentation of income two months after the child is enrolled based on the self-declared income information. Post-enrollment documentation of an eligibility requirement already exists in MCC/HFP. MCC requires verification of a beneficiary's SSN within 60 days of enrollment but not before approval of eligibility. HFP allows U.S. citizens or nationals to provide copies of their birth certificate up to 60 days after enrollment.

Several programs in California could be considered to implement presumptive eligibility. To do so, however, would require addressing multiple implementation challenges:

- Experience suggests that provider fraud will likely increase if presumptive eligibility for children is implemented under the provider-based model. The principal concern is about private entities that simultaneously conduct presumptive eligibility determinations and bill for MCC/HFP services, such as private MCC/HFP providers. Although tightening the provider enrollment process to better screen out providers with a prior history of Medi-Cal claiming or performance problems might presumably reduce the chances for fraud, early indications show that this intervention has not resulted in the hoped-for effect, when it was implemented for Medi-Cal provider enrollment.
- One issue to address with presumptive eligibility granted by means-tested programs under their program guidelines is the difference in how programs define family household for the purpose of calculating income. Other programs may consider family relationships and parenting status differently than do MCC/HFP. As a result, the income that is reported for one program, based on its definition of family household, may be different than the income that would be calculated under the MCC/HFP definition of family household. One way to mitigate this issue would be to allow presumptive eligibility only through programs whose household definitions include more people, and therefore potentially more income, than do MCC/HFP, but continue to evaluate these households under MCC/HFP income eligibility maximums.
- The ability to track, and potentially limit, the number of occurrences that a child could receive presumptive eligibility coverage is an issue. Many programs do not collect a SSN for their participants, and oppose collecting a SSN on behalf of MCC/HFP for the purposes of granting presumptive eligibility. Without a SSN, there is no practical way of tracking children who receive presumptive eligibility. Federal law does not permit the mandatory collection of SSNs for HFP.
- Another challenge will be the avoidance of granting presumptive eligibility for children who are already enrolled in MCC or HFP. Other states have found that often the families that avail themselves of health coverage outreach, or programs such as presumptive eligibility, have children who are already enrolled in health coverage programs. Providers or means-tested programs may have difficulty in determining which children are already receiving MCC or HFP benefits, and consequently grant benefits to children who already have coverage.
- Further research is needed to determine whether the provision of presumptive eligibility for children would require parents to provide a signature, and to selfdeclare their immigration status.

Several states (Connecticut, Michigan, New Hampshire, New Jersey, New York) currently allow presumptive eligibility for children in their Medicaid and/or SCHIP programs. Two states, New Jersey and Connecticut, only use health care providers

<sup>&</sup>lt;sup>33</sup> Currently, DHS does not track SSNs for pregnant women who receive presumptive eligibility for Medi-Cal or individuals who receive services through the Family Planning, Access, Care and Treatment (PACT) program. Both of these programs are described in further detail in this section and in the appendices.

such as acute care hospitals, federally qualified health centers, local health departments with primary care centers, and school-based clinics, as qualified entities. Other states (Michigan and New York) allow managed care plans to grant presumptive eligibility. Only one state, New Hampshire, allows means-tested programs like WIC and Head Start to grant presumptive eligibility. New Hampshire found that it is very difficult for these programs to conduct the presumptive eligibility determination, according to the Medicaid/SCHIP guidelines and consequently, very few programs are actually performing the process. The states indicate medical providers, hospitals, and community clinics may determine presumptive eligibility more accurately than other sites and are better at assessing children's immediate medical needs. All of these states shared similar concerns about fraud prevention, program integrity, and completion of actual enrollments for children who are granted presumptive eligibility. A description of these states' efforts is included in Appendix G.

Califomia currently allows presumptive eligibility through the Medi-Cal Presumptive Eligibility for Pregnant Women program as a result of state legislation (AB 501, Chapter 1127, Statutes of 1992). This program is intended to encourage low-income, pregnant women who are potentially eligible for Medi-Cal to start their prenatal care as early as possible. The Presumptive Eligibility for Pregnant Women program offers a very limited scope of benefits provided by a limited number of providers. Qualified presumptive eligibility providers provide these women with immediate, temporary Medi-Cal coverage for prenatal services. They must apply for Medi-Cal by the end of the month following the month in which their presumptive eligibility began. Since presumptive eligibility for a pregnant woman does not cover the cost of a baby's birth, participants have an added incentive to start and complete the Medi-Cal application process in order for Medi-Cal to cover the cost of delivery. DHS does not have data on the number of clients who have received presumptive eligibility and subsequently become enrolled in Medi-Cal. To date, there have been no reports of fraud in the program. Further information about this program is in Appendix D.

One approach to implementing presumptive eligibility for MCC and/or HFP would be to model it upon the current service delivery system operated by the Family Planning, Access, Care, and Treatment (PACT) program. Family PACT provides comprehensive family planning services to low-income individuals to reduce the likelihood of unintended pregnancy and to promote reproductive health. Any Medi-Cal provider (public or private) who agrees to abide by Family PACT standards of care may become a Family PACT provider. Providers are responsible for determining eligibility of applicants and completing on-site enrollment of eligible persons. Individual providers are issued a set of pre-numbered Health Access Program (HAP) cards, which are given to participants as proof of enrollment to receive services. It is important to emphasize that substantial fraud tactics would need to be designed and tested prior to using the limited-scope Family PACT as a model for full-scope Medi-Cal. Additional information about Family PACT is provided in Appendix C.

A few income-tested programs indicate that it would be possible to implement presumptive eligibility through their program. These include Food Stamps, WIC, CHDP, Child Care, State Preschool and Head Start. In this case of Food Stamps, the granting of presumptive eligibility would function more like an "accelerated enrollment," because screening would be conducted by county EWs, who are already using accepted

screening logic. In addition, presumptive eligibility could be implemented through the Child Support program; and at schools by school nurses, public health nurses or school-based programs that collect income information (i.e., Head Start and Healthy Start).

## Implications for Implementation and Enrollment

- Applicants in need of urgent, but non-emergency medical care, can receive care immediately in an appropriate health care setting (i.e., not an emergency room) once they have been granted presumptive eligibility.
- Accelerated enrollment may provide the necessary inducement to parents to fully enroll their children in the program so that they maintain access to services (e.g., they more fully realize the benefits of coverage).
- There is increased potential for fraud with more entities simultaneously determining MCC/HFP presumptive eligibility and billing for services rendered.
- Controlling repetitive episodes of presumptive eligibility for children would be very
  difficult without having a SSN to track each episode. Most programs do not collect
  SSNs, and federal law does not permit the mandatory collection of SSNs for HFP.
- There is potential for children already enrolled in MCC or HFP to be granted presumptive eligibility by a provider or means-tested program if the provider or program was unable to determine and verify the child's health coverage status.
- Citizenship and immigration verification is required for MCC/HFP. Other programs do not collect such information. If this information is not collected at the initial determination of income eligibility, there is the potential that some children who do not meet the citizenship and immigration requirements will receive services for which they are not actually eligible.
- Granting presumptive eligibility for fee-for-service Medi-Cal only and claiming the
  appropriate federal match post-enrollment would avoid the difficulty of determining
  whether an applicant should be presumed income eligible for MCC or HFP based on
  gross income information that is collected by many programs.
- Staff time, training, and resources will be required to learn about MCC/HFP, identify
  uninsured children, grant proof of presumptive eligibility for MCC/HFP, notify families
  about the programs' other eligibility requirements including citizenship and
  immigration status, give families application and other materials needed to complete
  enrollment, and transmit the child's contact and eligibility information to MCC/HFP
  with notification that presumptive eligibility was granted. The MCC/HFP outreach
  campaign would need to conduct additional training for these programs about
  MCC/HFP.

# TABLE 1.: COMPARISON OF MCC/HFP ELIGIBILITY REQUIREMENTS AND DETERMINATION METHODS WITH THOSE OF OTHER INCOME-TESTED PROGRAMS

	MCC/HFP	FOODSTAMPS	wic	CHDP	NSLP	HEAD START	CHILD CARE/ STATE PRESCHOOL	CHILD CARE FOOD
Income limits	MCC Children 0-1: 0-200% FPL Children 1-5: 0-133% FPL Children 6-18: 0- 100% FPL HEP Children 0-1: 200%- 250% FPL Children 1-5: 133%- 250% FPL Children 1-8: 100%-	Grossincome cannot exceed 130% FPL Nat income cannot exceed 100% FPL	Children 0-5: upto 185% FPL	Children 0-18: 200% FPL	Free: 0-130% FPL Reduced: 131-185% FPL	Children 0-5: 100%FPL (programs may include 10% over-income families)	Child Care Children 0-14: 75% State Medan Income (SMI) State Preschool Children 3-5: Approx 60% SMI	Free: 0-130% FPL Reduced: 131-185% FPL
Certain types of income not counted?	Yes	Yes	Yes	No. Incomeis self- declared.	Yes	Yes	Yes	Yes
Gross or net income used?	Net	Both Gross and Net Used	Gross	Gross	Gross	Gross	Gross	Gross (Net for self-employed)
Income deductions allowed?	Yes	Yes (same differences from MCC/HEP)	N/A	N/A	N/A	N/A	N/A	N/A
Documentation of income and deductions (ff allowed) required?	Yes	Yes	Documented but not verified	No	No	Yes	Can be self-reported	No
Citizenship and immigration status a factor?	Yes	Yes	No	No	No	No	No	No
Household composition	Medi-Cal counts these people as adults: natural or adoptive parents, stepparents, stepparents, emancipated minors, and minors fiving on their own and supporting themselves. These people are counted as children: unborn children, siblings under 21, and siblings under 21 away at schod and claimed as tax dependents. SSI/SSP recipients, CalWORKs recipients, and nonsiblings under 21 are nd counted.	Food Stamps households are comprised of people who reside together and customailly purchase and prepare their meds together. Differences from MCC/HFP. unborn children, siblings under 21 away at schod and claimed as tax dependents, boarders, and ineligible immigrants are not counted.	Differences from MCC/HFP: WIC does not count minors living on their own who are self-supporting or siblings under 21 away at schod and dairmed as tax dependents WIC counts SSVSSP recipients and CaWO RKs recipients as adults or children depending upon their ages.	Families without Med- Cal are asked how many people are in their family. This numberis used as the househdd size.	Differences from MCC/HFP: all adults in the househdd are counted, emandpated minors are considered children, minors living on their own and supporting themselves and unborn children are not counted; all children under 21, SSI/SSP redpients, and CalWORKs recipients are counted.	Differences from MCC/HFP: CalWORKs recipients and all children under 21 are counted.	Differences from MCC/HFP: emandpated minors are considered children; minors living on their own and supporting themselves, sblings under 21 away a school and claimed as tax dependents, and unborn children are not counted; SSVSSP reopients and CalWORKs recipients are counted as adults or children depending on their ages; and all children under age 18 living in the home are counted.	Differences from MCC/HFP: all adults and children under 21 who contribute to family income are counted; unborn children are not counted; SS/SSP recipients are counted as adults or children (depending on age) only if they contribute to family income; and CalWO RKs recipients are counted.

# **Chapter IV: Critical Issues for All Programs**

Implementation of each option would have implications both for MCC/HFP and the other programs involved. While each of these other programs expressed interest in coordination with MCC/HFP in some way, they also shared common concerns about the impact that implementation would have on their own programs. There are two critical crosscutting issues to highlight for further consideration.

1. There would be a significant workload and fiscal impact on certain programs and schools, resulting from any efforts to streamline application and enrollment for MCC and HFP.

There are certain steps a program or school would follow to implement any one of options A (referral with contact information), B (on-site assistance), D (share eligibility information), or E (presumptive eligibility).<sup>34</sup>

These steps include:

- Identify whether a child is uninsured;
- Inform the family about MCC and HFP and the child's likely income eligibility for one of the programs; and
- Explain that MCC and HFP collect citizenship and immigration information for the applicant child(ren) only, and that MCC/HFP would follow up with the family for this information if an application is initiated.

Next, depending upon the option, the program would do one or more of the following:

- Give the family a MCC/HFP application or referral form or obtain parental consent to share only the child's contact information with MCC/HFP and send that information (option A);
- Assist with the completion and submission of a joint MCC/HFP application (option B);
- Obtain consent to share both the child's contact and eligibility information and send that information to MCC/HFP (option D); and/or
- Perform a presumptive eligibility screening, give the child proof of presumptive eligibility (if eligible) and materials to complete enrollment, and send the child's contact and eligibility information to MCC/HFP with notification that presumptive eligibility was granted (option E).

Each interaction with a family about health insurance status and MCC/HFP eligibility and requirements could range between 5-15 minutes, or require more time if families have additional questions and concerns. In addition to the time spent with each family,

<sup>&</sup>lt;sup>34</sup> Option C (common application) is not included because it is not feasible for, or preferred by, any additional program at this time.

transmittal of the information to MCC/HFP will require ongoing staff time and resources as well as initial staff time and resources to design and implement the process.

To complete these functions, training and additional resources will be needed given that programs are generally prohibited from using their own program funds for non-program activities, and schools do not have resources for health insurance related efforts. Currently, some programs and schools (i.e., WIC and School Health Connections) are supporting such efforts with funding from Foundations. Without additional resources, it is likely that most local programs and schools that have the discretion to implement these options will choose not to implement.

Some programs and schools may support some of these activities with federal Medi-Cal Administration Activities (MAA) funds. MAA funds can be used for outreach, facilitating the Medi-Cal application, Medi-Cal non-emergency, non-medical transportation, contracting for Medi-Cal services, program planning and policy development, and MAA coordination and claims administration. MAA is a voluntary program for Local Government Agencies (LGAs), which are counties and chartered cities, and Local Educational Consortium (LECs), which are eleven service regions to the County Superintendent Educational Services Association.

Schools or Local Education Agencies (LEAs) have the option to participate in MAA either through an LGA or an LEC. Agencies that choose to participate in MAA must comply with the requirements established by DHS including:

- Participation annually in a one-month MAA time survey;
- Preparation of a MAA claiming plan that describes the activities that will be claimed;
- Preparation of a contract with DHS;
- Preparation of quarterly MAA invoices; and
- Certification of local funds to match the federal share that will be reimbursed.

Costs associated with MAA are matched at the federal financial participation (FFP) rate, which is currently 51.25 percent. DHS has delegated authority to DMH to administer the MAA program for participating county mental health programs.

Beyond the costs to the other programs, implementation of the options would also have a financial and workload impact on MCC and HFP, including DHS, MRMIB and the MCC/HFP outreach campaign. Depending on the options adopted, MCC/HFP will be required to modify existing enrollment processes and conduct more follow-up with applicants. This additional workload will entail increased administrative costs for county Medi-Cal staff, SPE, and the HFP administrative vendor.

2. There could be a potential impact on the enrollment of other programs and schools if they are to function as a gateway into MCC and HFP.

MCC requires applicants to provide proof of legal immigration to receive the full range of benefits, as mandated under Federal law. HFP requires proof of legal immigration, as

federally mandated, and proof of citizenship as required by state HFP regulations. Schools and most of the other programs involved in this report do not require such information and avoid any reference to citizenship and immigration, except to reassure applicants that this issue will have no bearing on the child's participation. Other programs and schools are regarded as trusted sources of information for all children and families, regardless of citizenship and immigration status.

For programs and schools to maintain this level of trust, families will need to understand fully the MCC/HFP citizenship and immigration requirements. Otherwise, families may be surprised when this citizenship and immigration information is requested by MCC/HFP, and feel that the other program has acted inappropriately in sharing the family's information. At the same time, these other programs need to explain to families that MCC/HFP will request citizenship and immigration information only for a child for whom coverage is requested, and that this confidential information is needed only to determine eligibility. The goal is to provide full and clear information so that families can grant informed consent under all circumstances.

MCC/HFP are sensitive to these concerns and committed to working with the programs and schools to address these issues. Further work is needed to identify a range of steps that DHS and MRMIB could take to alleviate these concerns. Possible steps include:

- Working with the programs to develop uniform forms and consistent questions for obtaining parental consent to share confidential contact and/or income information with MCC/HFP; and
- Developing additional educational materials targeted to immigrant communities.

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<sup>&</sup>lt;sup>35</sup> The exceptions are CalWORKs and Food Stamps, which do require applicants to provide proof of citizenship or legal immigration.

# **Chapter V: Findings**

This chapter presents the most promising options for each of the programs based upon input received from state and local level program representatives. The promising options presented here are not exclusive; rather, they could be implemented in combination through a single program. More detailed information about each program and its role in streamlining MCC/HFP application and enrollment processes is presented in the program profiles in <a href="Appendix E">Appendix E</a>. <a href="Table 2">Table 2</a> on Page 55, provides a snapshot of promising options for each of the programs.

#### Food Stamps Program

Options: A, B, D, E

All children participating in the non-assistance Food Stamps program (i.e., not also receiving CalWORKs) are very likely eligible for MCC or HFP because the Food Stamps eligibility requirements and determination methods are very similar to those of MCC/HFP. However, these children do not have automatic eligibility for MCC, and may not get a referral to MCC or HFP in some counties.<sup>36</sup> State administrative data indicate that there are about 46,000 children receiving non-assistance Food Stamps who are not enrolled in either MCC or HFP.

One approach to promote MCC/HFP enrollment among Food Stamps children would be to "deem" them to have met the eligibility requirements for participation in MCC/HFP. Children from birth up through age 5 are very likely eligible for MCC and could be deemed eligible for that program. The Food Stamps program, however, does not have eligibility requirements and determination methods that, for every participant, are equal to or more restrictive than those of Medicaid. The major differences between Food Stamps and MCC/HFP that make deeming a challenge are that Food Stamps computes household composition differently and allows for different income deductions than MCC/HFP. Federal flexibility and modifications in State policy would be needed to permit deeming of MCC/HFP eligibility for Food Stamps participants, including those children from birth through age 5.

Alternatively, there are four other options to consider for Food Stamps:

 One option is to require Food Stamps EWs to routinely conduct referrals to MCC/HFP. Food Stamps EWs could check MEDS to see if an applicant is receiving Medi-Cal or HFP. If not, the EW could provide the applicant with information on Medi-Cal and/or HFP and/or refer the person to a Medi-Cal EW. In addition, information could be mailed to existing non-assistance Food Stamps households to inform them of how they could get more information about MCC/HFP.

<sup>36</sup> A referral process already exists between CalWORKs, Food Stamps and Medi-Cal because there is a common application for these programs. However, when a family applies for non-assistance Food Stamps using a Food Stamps-only application form, there is no automatic direct referral to other

services/programs.

- Another option is to require Food Stamps offices to provide on-site assistance
  with the joint MCC/HFP application. Some counties make the joint application
  available on site, and will accept the forms and forward them to the HFP SPE for
  processing. Rarely, however, do counties provide assistance to families in
  completing the application. Those counties that offer such assistance often do
  so in partnership with community-based organizations.
- A third option involves the sharing of eligibility information between Food Stamps and MCC/HFP. County social services departments that administer the Food Stamps program could be required to conduct matches of Food Stamps and MEDS data to identify children already enrolled in Food Stamps who are not receiving MCC or HFP. (This data match has been conducted at the State level. and such information will be shared with the counties.) Via the mail, counties could obtain permission from families of uninsured children to use information in the Food Stamps case file to conduct an eligibility determination for MCC and forward information to HFP for children who do not qualify for MCC or have a share of cost. The county or HFP may need to contact the families to obtain information needed to determine MCC/HFP eligibility that is not provided in the Food Stamps case file. In addition, Food Stamps EWs could ask all nonassistance Food Stamps applicants, at the point of intake, about their desire to apply also for MCC/HFP using the same information the family has provided for Food Stamps. This may occur in some counties already when the same EWs conduct determinations for both Food Stamps and MCC.
- A final option is to grant presumptive eligibility for children who receive Food Stamps. In this case, the granting of presumptive eligibility would function more like an "accelerated enrollment," because screening would be conducted by county EWs, who are already using accepted screening logic. Currently, counties have 45 days to determine MCC eligibility and 30 days to determine Food Stamps eligibility. Allowing Food Stamps EWs to grant presumptive eligibility for MCC could speed children's access to health care during the final eligibility determination period. However, since presumptive eligibility may not result in actual enrollment, and counties have access to Food Stamps case files for use in determining eligibility for MCC, pursuing the sharing of eligibility information with MCC/HFP may be preferable to granting presumptive eligibility. Another approach would be to implement the sharing of eligibility information and presumptive eligibility simultaneously. It would be possible to grant presumptive eligibility to children who have a MCC/HFP application pending by virtue of parental agreement to allow the county to use Food Stamps case file information for the MCC eligibility determination or to forward it to HFP.

# Supplemental Nutrition Program for Women, Infants and Children (WIC)

Options: A, B, C (automated only), D, E

All WIC infants up to age 1 are very likely income eligible for MCC, and all other children ages 1 to 5 receiving WIC are very likely income eligible for either MCC or HFP. WIC data show that about 285,000 children receiving WIC are not enrolled in MCC, but it is not known how many of these children may have another source of insurance such as HFP, or how many would not meet MCC/HFP citizenship and immigration requirements.

Currently, as part of the intake process, WIC agencies ask applicants whether they are receiving Medi-Cal. Agencies can link to the MEDS system to confirm the applicant's report and check for enrollment in HFP as well. However, agencies do not ask families about any other possible source of health insurance. To facilitate the identification of children who lack any source of coverage, WIC is in the process of adding a few additional questions to ISIS, its automated intake system.

Many local WIC offices routinely provide families with referrals to MCC/HFP or local CAAs, or offer on-site education and application assistance. These efforts could be built upon in several ways:

- One option is to expand referrals to other WIC offices, and have WIC offices use a standard MCC/HFP referral form that would provide MCC/HFP or a local CAA with a family's contact information so that follow-up activities can occur.
- Another option is to provide additional tools and resources to expand the provision of on-site education and application assistance. This could include locating Health-e-App terminals in WIC sites.
- WIC and MCC/HFP could also explore the development of a common automated application since WIC's ISIS is a statewide, automated intake system used by all WIC sites.
- Another option is for WIC offices to obtain parental consent to share a child's contact, income and other eligibility information directly with MCC/HFP to begin the application process. Differences between WIC and MCC/HFP would make it necessary for MCC/HFP to recalibrate household and income information received from WIC to meet MCC/HFP guidelines. WIC indicates that it would add only a few minutes to each WIC intake interview to obtain from the family the information about household composition and income needed by MCC/HFP to determine income eligibility. WIC would not inquire about citizenship and immigration status; such an inquiry would be the responsibility of MCC/HFP.
- A final option that poses more implementation challenges would be for WIC offices to grant MCC/HFP presumptive eligibility to children. This is permissible under Federal law.

#### Child Health and Disability Prevention Program (CHDP)

Options: A, B, D (limited), E

Many children served through CHDP and not enrolled in MCC are very likely income eligible for MCC or HFP. Currently, local CHDP programs are required to refer uninsured children to MCC/HFP. CHDP providers are encouraged to conduct referrals, though it is not common practice for providers. DHS has concerns about establishing requirements that CHDP providers refer to MCC/HFP because some CHDP providers may choose to discontinue their participation in the CHDP program.

There are a few possible options to consider for CHDP:

- CHDP could enhance the referral model by having local CHDP programs and providers distribute an official MCC/HFP referral form to families whose children are not enrolled in MCC or HFP.
- Some CHDP programs and providers are providing on-site application
  assistance, and others could be encouraged to do so if provided additional tools
  and resources. Providers could be encouraged to have their staff trained as
  CAAs or to establish relationships with CAAs who would come to their office to
  assist families.
- Another option for CHDP involves the sharing of family contact and possibly income information with MCC/HFP if parental consent is obtained. Parents whose children are not receiving MCC complete the CHDP Eligibility Information (DHS 4073) form at the CHDP provider's office at the time of the CHDP health examination. This form could be revised to request permission from participants to share their contact and eligibility information with MCC/HFP. In addition, the CHDP provider completes a Confidential Screening/Billing form known as the PM 160. The CHDP provider sends the PM 160 to Electronic Data Systems (EDS) for processing, and attaches DHS 4073 form, if a child is not receiving MCC. A copy of the PM160 is sent to the local CHDP program. At this time, the DHS 4073 and PM 160 and the data system do not include all the eligibility or contact information needed for MCC/HFP to follow up with families. Information system changes are needed so that the necessary information can be stored in the system and shared with MCC/HFP. In the absence of such changes, each local CHDP program could, with parental consent, transmit information from the PM 160 to MCC/HFP via fax or mail. However, because the DHS 4073 does not collect information regarding income or family size other than what the applicant self declares, extensive follow-up would be required by MCC/HFP to determine eligibility and enroll a child in MCC or HFP.
- Another option for CHDP, though it would pose more implementation challenges, would be to allow CHDP providers to grant presumptive eligibility for MCC/HFP. This is permissible under Federal law. Many CHDP providers may be interested in granting presumptive eligibility for MCC/HFP if they can then provide treatment services to those children with health needs identified during the CHDP examination.

# National School Lunch Program (NSLP) and School-Based Efforts

Options for NSLP: A

Options for Schools Overall: A, B, D, E

Schools rank as one of the top referral sources for MCC/HFP. Some school districts and schools currently distribute MCC/HFP information, a referral form, and/or applications along with school meal applications, at the beginning of the school year in welcome packets or during other special events such as back-to-school nights. Some schools provide application assistance on special days with assistance from outstationed MCC EWs or local CAAs. With additional resources, these referral and onsite assistance efforts could be expanded to other schools, and enhanced with assistance from community-based organizations and school-based or school-linked programs. For example, an official MCC/HFP referral form could be distributed each

year to every child enrolled in school. Parents would complete the forms and return them in a pre-paid postage envelope to MCC/HFP or to a local enrollment entity, which would conduct the necessary follow-up activities. The proposed MCC/HFP outreach campaign for 2001-2002 contains \$6 million in funding for school-based outreach.

To the extent that schools have school nurses, public health nurses, school clinics, or school-based programs such as Head Start and Healthy Start on site, these entities could assess children's health insurance needs and conduct referral, education and application assistance activities. They also could collect and share family income information with MCC/HFP to initiate the application process and/or grant presumptive eligibility at the school. Federal law allows schools to be qualified entities for the purposes of granting presumptive eligibility.

In addition, it is possible to target school-based efforts to schools with high numbers of children receiving free or reduced price meals and to children participating in the NSLP. All children receiving free or reduced price meals through NSLP are very likely income eligible for MCC or HFP. One option to streamline the MCC/HFP application and enrollment processes for these children would be for schools to share with MCC/HFP the *income and other relevant eligibility information* provided by families on the NSLP application. This approach is being used in Washington State. Alternatively, schools could provide MCC/HFP with *contact information only* from NSLP applications so that families would not need to complete a separate referral form. New York City is using this second approach. NSLP applications could be revised to include a check box for parents to grant consent to the release of their contact and/or eligibility information to MCC/HFP.<sup>37</sup>

According to CDE, the sharing of contact and/or detailed eligibility information from NSLP applications with MCC/HFP currently is not possible under the California Education Code, Sections 49557 and 49558. Section 49557 states that lists of children eligible for free and reduced price meals "shall not be...used for any other purpose than the National School Lunch Program." Section 49558 reiterates that applications and records shall be confidential and "shall not be open to examination for any purpose not directly connected with the administration of any free or reduced price meal program."

It is unclear whether, notwithstanding Sections 49557 and 49558, other provisions of the Education Code would permit the sharing of information from NSLP applications with parental consent; CDE has not provided clarification on this issue, but instead maintains the position that the confidentiality provisions in these sections are essential to ensure applicants' trust and maintain children's access to NSLP meals. CDE also

<sup>&</sup>lt;sup>37</sup> The option of revising the NSLP application to obtain such parental consent is not possible when schools use direct certification or an alternative daiming mechanism for the NSLP. Instead, these schools could send a separate consent form home with children participating in the NSLP so that, at a minimum, families could grant permission for schools to forward their contact information to MCC/HFP.

<sup>38</sup> The Federal Agriculture Risk Protection Act (P.L. 106-224) and subsequent regulations from USDA allow the sharing of eligibility status (i.e., contact information) for federal nutrition programs (i.e., National School Lunch, Child Care Food) with other select federal and state programs, including health insurance programs, without parental consent. Detailed eligibility information, however, may not be shared with other such programs without consent. In this case, Federal law is superseded by the more restrictive State Education Code.

indicates that other sections of the Education Code that permit the sharing of "pupil records" with parental consent are not applicable to NSLP information.<sup>39</sup>

CDE is working with NSLP sponsors to identify strategies to promote awareness of MCC/HFP and increase enrollments. Some NSLP sponsors have attached MCC/HFP promotional materials and contact information to the NSLP application. This approach has been successful in a variety of pilot programs. However, NSLP sponsors have several concerns about adding any type of parental release language for the MCC/HFP, either on or attached to the NSLP application. Based on these reasons, CDE recommends the use of a separate MCC/HFP referral form attached to the NSLP application that would allow a NSLP applicant to share his/her contact information with MCC/HFP.

#### **Child Care Food Program**

Options: A, B, C

All children receiving free or reduced meals through the Child Care Food program are very likely income eligible for either MCC or HFP. However, there is no formal linkage between Child Care Food and MCC/HFP, though some local child care food agencies may provide families with MCC/HFP information and materials on a limited basis.

There are three options to consider for Child Care Food:

 One option would be to establish a referral process to MCC/HFP. Local child care food agencies that contract with CDE could distribute and collect from families a standard referral form to request information and an application for MCC/HFP. The Child Care Food program shares similar concerns as the NSLP in regard to releasing contact information from the child care food application to MCC/HFP. These concerns include the need to maintain applicant confidentiality and the feasibility of obtaining parental consent.

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<sup>&</sup>lt;sup>39</sup> Education Code Section 49075 provides that "a school district may permit access to pupil records to any person for whom a parent of the pupil has executed written consent specifying the records to be released and identifying the party or dass of parties to whom the records may be released." CDE interprets the definition of "pupil record" as defined in Education Code Section 49061(b) narrowly. Thus, CDE maintains that Education Code Section 49075, which permits the release of information from pupil records, does not apply to the release of contact or eligibility information from a NSLP application. <sup>40</sup> First, MCC/HFP requires documentation of legal immigration status, and HFP requires documentation of citizenship status. This documentation is not required to obtain meals under the provisions of the NSLP. NSLP sponsors provide outreach and encouragement for all children eligible to participate in the program and feel that an additional requirement to add a MCC/HFP parental release option, or "check off" box to request MCC/HFP information on the NSLP application, would deter applicants from applying for either NSLP or MCC/HFP. Another sponsor concern is potential liability related to assurances of confidentiality, if the applicant does not understand the consequences associated with selection of the option releasing information to MCC/HFP. Sponsors do support providing information about the program, but ask that this information be provided as a separate document. This document would be distributed simultaneously with the NSLP applications during other promotional opportunities. In addition, if eligibility information and SSNs from the NSLP application are shared with persons making MCC/HFP eligibility determinations, modifications would be necessary to the privacy disclosure information on the NSLP application, which poses an additional concern. Another major concern for NSLP sponsors is the increase in workload. If parental consent for sharing enrollment information with MCC/HFP is required as part of the NSLP application, there would be added staff requirements, including establishing required procedures; answering questions; and making appropriate referrals.

- A second option would be for local child care food agencies to provide on-site application assistance. Some programs may be willing to perform this activity.
- A third option would be for the local child care food agencies to inform families about MCC/HFP and obtain parental consent to share contact and income eligibility information collected on the Child Care Food application with MCC/HFP. This option is allowable under Federal law. However, CDE opposes the sharing of Child Care Food contact and eligibility information for the same reasons that apply to the NSLP.

#### **Child Care and State Preschool Programs**

Options: A, B, D, E

All children participating in the Child Care and State Preschool programs are very likely income eligible for either MCC or HFP. Currently, child development agencies that contract with CDE to serve families through these programs interview parents in person, and are required to ask questions about families' health and social services needs at application and during re-certification and make the appropriate referrals. Despite this requirement, many agencies do not routinely make referrals to MCC/HFP.

There are four possible options to consider for Child Care and State Preschool:

- To promote referrals to MCC/HFP, child development agencies could distribute a standard MCC/HFP referral form and collect the forms from families wishing to obtain MCC/HFP information and an application.
- Child development agencies also could be encouraged to provide on-site application assistance by having CAAs or out-stationed EWs present on site to talk with families during State Preschool enrollment weeks and Child Care parent education meetings.
- Child development agencies could obtain parental consent to share income
  eligibility information with MCC/HFP. CDE indicates that it would prefer that a
  separate form be used to obtain parental consent, rather than revise the existing
  locally designed application forms.
- Child development agencies could grant presumptive eligibility for MCC; however, CDE has concerns about the implementation challenges of this option.

#### Federal Head Start Program

Options: A, B, D, E

There are over 83,000 children under age 5 currently enrolled in Head Start programs in California. At least 90 percent of these children live in families with incomes under 100% of the FPL and would therefore, meet MCC income requirements. Ten percent of the children served may have family incomes exceeding the 100% FPL limit. Some children may be in the program by virtue of being in foster care, receiving SSI, or being children of former CalWORKs participants. Such children have categorical eligibility for MCC and are likely already enrolled in that program.

There are several promising options to consider for Head Start:<sup>41</sup>

- Due to Head Start's requirement that all children have a "medical home," most Head Start programs routinely connect children to health insurance programs through referrals or the provision of on-site application assistance. These efforts could be expanded to all Head Start programs and enhanced through the use of a standard MCC/HFP referral form so that family's contact information could be shared with MCC/HFP or local CAAs for follow-up purposes. Another enhancement would be to provide additional resources to support on-site application assistance, and to locate Health-e-App terminals in some Head Start centers.
- Another promising option would be for Head Start staff to obtain parental consent to share contact, income and other eligibility information with MCC/HFP to initiate the MCC/HFP application process. There is no Federal prohibition to releasing information with a parent's consent in the Head Start program.
- A final option with more implementation challenges would be to allow Head Start centers to grant presumptive eligibility to children for MCC. This is permissible under Federal law.

## Child Support Program

Options: A, B, D, E

Almost every court order for child support also includes an order for medical support. However, the Child Support program currently does not promote enrollment into MCC or HFP. Federal policy currently prohibits the use of Federal Child Support (Title IV-D) funding for efforts to seek enrollment for children in Medicaid or SCHIP. Instead, the program pursues employer-provided health insurance through the non-custodial parents. However, the Child Support program could assist income-eligible families with enrollment into MCC or HFP after it has been determined that employer-provided coverage is not immediately available. Local child support agencies collect income information for both parents, though information is often not available for non-custodial parents. Since MCC/HFP income eligibility is based upon the custodial parent's income, however, lack of income information about the non-custodial parent should not pose a barrier to promoting MCC/HFP enrollment through the Child Support program.

There are a few promising options to consider for Child Support:

 Child support agencies could provide routine referrals to MCC/HFP and distribute an official referral form. When HFP was created, DCSS mailed MCC/HFP outreach materials to each local child support agency and HFP staff attended conferences to present HFP information to local child support staff; however, current county outreach and referral efforts vary.

 $<sup>^{41}</sup>$  Due to the Head Start program's local-to-Federal link, the State could not mandate that Head Start programs implement these options. Participation could be encouraged only.

- Child support agencies could offer on-site MCC/HFP education and application assistance, perhaps through the location of Health-e-App terminals in county Child Support program offices.
- Another promising option would be for child support agencies to obtain parental
  consent to share income information with MCC/HFP for uninsured children who
  appear to meet the income requirements MCC or HFP. Although the Federal
  Child Support program is authorized to exchange information with the Medicaid
  program, as a matter of policy DCSS would want to ask the family if it is
  interested in applying for MCC/HFP and obtain permission to send information to
  those programs.
- Another option, though with more implementation challenges, would be to allow child support agencies to grant presumptive eligibility for MCC. This is permissible under Federal law, and DCSS is reviewing the feasibility of this option.

#### **Alcohol and Other Drug Programs**

Options: A, B, and D on a limited basis

Alcohol and other drug programs, such as peri-natal and youth treatment programs, do not consistently collect income or other eligibility information from children and families. To the extent that income information is collected, these programs could obtain parental consent to share the information with MCC/HFP. More promising, however, are the options to establish standard referral processes between these programs and MCC/HFP, and/or to provide education and on-site application assistance for MCC/HFP at some of the program sites.

#### **Mental Health Services**

Options: A, B, and D on a limited basis

County mental health departments and contracted treatment providers do not consistently collect income or other eligibility information from children and families. To the extent that income information is collected, these programs could obtain parental consent to share the information with MCC/HFP. More promising, however, are the options to establish standard referral processes between these programs and MCC/HFP, and/or to provide education and on-site application assistance for MCC/HFP at some of the program sites.

#### **Developmental Services Regional Centers**

Options: A and B only

Developmental Services Regional Centers, which fund a variety of services to individuals with developmental disabilities, do not collect income or other financial eligibility information. The most promising options for the regional centers are to establish a referral process with MCC/HFP, and/or to provide education and on-site application assistance for MCC/HFP.

#### Child Welfare Services (CWS)

Options: A only

County child welfare services agencies do not collect income or other eligibility information from children and families. Alternatively, the most promising option is to establish a standard referral process with MCC/HFP. The option of providing on-site application assistance is not recommended by DSS because of limited social worker time and resources.

## **Answers Benefiting Children (ABC) Projects**

Options: A, B, and D on a limited basis

Local Answers Benefiting Children (ABC) projects may collect income or other eligibility information from children and families, though this information is not required. To the extent that income information is collected, these projects could obtain parental consent to share the information with MCC/HFP. More promising, however, are the options to establish standard referral processes between these programs and MCC/HFP, and/or to provide education and on-site application assistance for MCC/HFP at some of the program sites.

# **Unemployment Insurance (UI) Program**

Options: A only

The Unemployment Insurance (UI) program does not collect income or other eligibility information for program recipients; however, it is possible to establish a referral process with MCC/HFP whereby referral forms are distributed to UI claimants and MCC/HFP information is posted on the UI website. Provision of on-site assistance is limited by the fact that the majority of UI applications are taken over the phone.

TABLE 2.: PROMISING OPTIONS AND NUMBER OF ELIGIBLE CHILDREN POTENTIALLY REACHED

						Ĭ		
PROGRAMS, SYSTEMS & CENTERS	# CHILDREN SERVED THROUGH PROGRAM OR SYSTEM	# CHILDREN SERVED WHO ARE UNINSURE D	# CHILDREN VERY LIKELY INCOME ELIGIBLE FOR MCC OR HFP	ESTABLISH OR ENHANCE REFERRAL PROCESSES	ON-SITE EDUCATION AND ASSISTANCE	COMMON APPLICATION	SHARE AND USE INCOME AND OTHER ELIGIBILITY INFORMATION	GRANT PRESUMPTIVE ELIGIBILITY
FOOD STAMPS	443,000	46,000 A RE NOT ON MCC OR HFP	ALL	х	Х		Х	Х
WIC	750,000	285,000 ARE NOT ON MCC*	ALL	Х	х	X (AUTOMATED ONLY)	х	x
CHDP	2 MILLION	1 MILLION ARE NOT ON MCC (may be duplicated count)	ALL	х	х		X (LIMITED, WOULD FUNCTION MORE LIKE A REFERRAL)	х
NSLP	2 MILLION	UNKNOWN	ALL	Х				
SCHOOL- BASED EFFORTS (ALSO HEALTHY START)	5.8 MILLION	UNKNOWN	UNKNOWN	х	х		х	х
CHILD CARE FOOD	430,000	UNKNOWN	AT LEAST 90%	Х	Х		Х	
CHILD CARE AND STATE PRESCHOOL	193,000	UNKNOWN	ALL	Х	Х		Х	X
HEAD START	83,000	UNKNOWN BUT LOCAL PROGRAMS MAY KNOW	ALL	х	х		Х	х
CHILD SUPPORT	2 MILLION CASES; MEDICAL ORDERS FOR 1 MILLION	20,000 HAVE PRIVATE INSURANCE	UNKNOWN, BUT 1/3 CASES CURRE NTLY ON CALWORKS	х	х		х	х
ALCOHOL AND OTHER DRUG PROGRAMS	538,000	UNKNOWN	UNKNOWN	Х	х		X (LIMITED)	
MENTAL HEALTH SERVICES	150,000	20% ARE NOT ON MCC/HFP	UNKNOWN FOR THIS 20%	х	х		X (LIMITED)	
DDS REGIONAL CENTERS	93,000	UNKNOWN	UNKNOWN	х	Х			
CHILD WELFARE SERVICES	306,000	UNKNOWN**	UNKNOWN	х				
ABC PROJECTS	6,500	UNKNOWN	UNKNOWN	Х	Х		X (LIMITED)	
UNEMPLOY- MENT INSURANCE	UNKNOWN	UNKNOWN	UNKNOWN	Х				

<sup>\*</sup> A data match is underway at the State level to determine how many of these children are enrolled in

HFP.

\*\* Children receiving child welfare services who enter the Foster Care system are automatically eligible for MCC.

# APPENDIX A: Description of Medi-Cal for Children (MCC)

# **Background**

The Federal government created the national Medicaid program in 1965 through Title XIX of the Social Security Act to provide health care coverage to poor and low-income families and specific individuals who lack health insurance. California's Medicaid program, Medi-Cal, is administered by the California Department of Health Services (DHS). At the federal level, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services oversees the Medicaid program. Jointly funded by the State and Federal government, Medi-Cal is the primary source of health care coverage for over 5.1 million Californians, most of whom are children (approximately 2.7 million). Within Federal guidelines, DHS establishes how to administer the Medi-Cal program, eligibility rules, what services are covered and the rate paid for services. The Medi-Cal program has evolved into a complex network of public and private health care providers serving approximately 16 percent of the state's population, and has the largest number of beneficiaries of any Medicaid program in the country.

# Eligibility Requirements

In general, Medi-Cal recipients are very low-income families and individuals who are elderly or disabled and have limited means to pay for the cost of health care. To be eligible for Medi-Cal, a family or individual must meet Medi-Cal's property, income, institutional status, residency and citizenship requirements and be "linked" to the program through one category of eligibility. Most of these eligibility categories can be grouped into one of several broad classifications as indicated below:

- 1. Public (Cash) Assistance:
  - Be a CalWORKs recipient (formerly the Aid To Families with Dependent Children program) or a Supplemental Security Income/State Supplement Payment recipient (SSI/SSP) who is aged, blind, or disabled according to Social Security rules.
- 2. Medically Needy or Medically Indigent:
  - (a) The medically needy are uninsured families and individuals who have incomes too high to qualify for cash assistance, but who otherwise qualify for CalWORKs or SSI/SSP. The medically needy category also covers individuals who are eligible for public assistance but has chosen not to receive it.
  - (b) The medically indigent are low-income pregnant women, children under 21 years of age, adults in long-term care who do not qualify for public assistance or as medically needy.
- 3. Federal Poverty Level (FPL) Programs:
  - Individuals who qualify for Medi-Cal under a FPL program are:
  - (a) Pregnant women and infants in families with incomes at or below 200 percent of FPL.

- (b) Children aged 1-5 in families with incomes at or below 133 percent of FPL.
- (c) Children aged 6-18 in families with incomes at or below 100 percent of FPL. Coverage for children under the FPL percent programs is referred to as the Medi-Cal for Children (MCC) program.
- 4. Other Eligibility Groups include:
  - (a) Transitional Medi-Cal (e.g., families transitioning from CalWORKs to employment).
  - (b) Qualified low-income Medicare recipients.
  - (c) Individuals in special treatment programs (e.g., tuberculosis and kidney dialysis).
  - (d) Refugees.
  - (e) Undocumented immigrants (who are eligible for emergency and pregnancy related services only).

The basic rule in determining a person's eligibility for Medi-Cal is to evaluate the individual and, when possible, the entire family, for the coverage category that provides the most comprehensive coverage without requiring the individual or family to pay a share of the cost for services.

## Immigration and Citizenship Requirements

U.S. citizens, legal permanent residents, and certain other immigrants (i.e., refugees and legal immigrant children who entered the country after 8/22/96) may receive the full range of Medi-Cal covered services, provided they meet other eligibility requirements. For undocumented and certain other immigrants, Medi-Cal will cover only emergency and pregnancy-related services, as well as some nursing home care.

#### **Benefits**

Federal Medicaid law mandates that Medi-Cal provide comprehensive preventive, acute and long-term physical, mental health, and substance abuse services to beneficiaries, including:

- (a) Inpatient and outpatient hospital care,
- (b) Physician and other medical provider services,
- (c) Skilled nursing facility care,
- (d) Home health,
- (e) Laboratory and x-ray services, and
- (f) Transportation.

In addition, all children under age 21 enrolled in Medi-Cal must receive Early Periodic Screening Diagnosis and Treatment (EPSDT) services, which include wide-ranging diagnostic services and medically necessary treatment.

Federal regulation also allows states the option of including additional services in Medicaid plans. California has chosen to cover 32 of 34 optional services (e.g., prescription drugs, dental care, vision care, hospice care, inpatient psychiatric care and rehabilitation and therapy services). The state also offers Minor Consent, or Sensitive Services, which provides treatment for mental health, sexually transmitted infections, drug and alcohol abuse, sexual assault, family planning, pregnancy and pregnancy-related services without parental consent.

# Application and Enrollment Process

County welfare departments determine Medi-Cal eligibility. The state establishes eligibility criteria within federal guidelines, which the counties then implement. Although the application and enrollment process for applying to Medi-Cal may vary for different eligibility groups, certain procedures for determining eligibility and enrolling in the program exist for all applicants. A person may apply for Medi-Cal in various ways. For those receiving SSI or CalWORKs benefits, receipt of Medi-Cal is automatic and does not require the person to appear at a county social services office. Others may apply at the county social services office, or at a hospital or clinic where a county eligibility worker is sometimes out-stationed. Families may also use the Medi-Cal for Children/Healthy Families Program mail-in application to apply for Medi-Cal for children under the age of 19 or for a pregnant woman. These completed applications may be brought to a county welfare department or may be mailed to the state's Single Point of Entry (SPE) processing location. The SPE screens all applications for Medi-Cal or HFP eligibility and sends applications for children that appear to be Medi-Cal eligible to the appropriate county by overnight mail. County eligibility workers (EW) review these applications.

An EW assists in completing the required forms and collects documentation (e.g., proof of household address, income and income deductions, citizenship or immigration status). Some applicants may need to return to the county office to provide additional documentation or complete additional forms as requested.

Due to the proposed expansion of the HFP to also cover adults, DHS and MRMIB are currently in the process of developing a new mail-in application for all applicants to use when applying for benefits for parents and children under Medi-Cal or the HFP. In addition to allowing families to apply on behalf of parents and children under either program on one application, the goal is to significantly expedite the Medi-Cal application and enrollment process. By using the mail-in application, applicants will no longer need to apply for Medi-Cal for adults in person or have a face-to-face interview.

Specific information collected by the county is electronically submitted to the state where crosschecks are conducted to verify reported information. Federal law mandates that a Medi-Cal determination be made within 45 days of the application date. However, when the Medi-Cal application is based on disability, the completed eligibility process must be made within 90 days from the date of application.

## **Expansion**

As part of California's State Children's Health Insurance Program (discussed further under the Healthy Families Program description in Appendix B), pursuant to state law (SB 903 and AB 217), Medi-Cal made two changes to the percent programs effective March 1, 1998. First, Medi-Cal began disregarding resources of children in the percent programs. Secondly, Medi-Cal adopted the new federal option to allow children up to age 19 to be covered immediately under the 100 percent program without having to wait for the mandatory phase in period to expire. 42

<sup>42</sup> That provision required that children had to be born after September 30, 1983 to be covered.

# Appendix B: Description of THE Healthy Families Program (HFP)

## **Background**

In 1997 the federal government established the State Children's Health Insurance Program (SCHIP), which provides federal matching funds for states to expand health coverage for low-income children. States can implement their SCHIP programs in one of three different ways: 1) by expanding their existing Medicaid program, 2) by implementing a separate, state-designed children's health insurance program, or 3) by adopting a combined approach. California chose to implement its SCHIP program through the combined approach by expanding Medi-Cal, and establishing the Healthy Families Program (HFP), a separate children's health insurance program. Assembly Bill 1126 (Villaraigosa), passed in October 1997, established the HFP and designated the Califomia Managed Risk Medical Insurance Board (MRMIB) as the program administrator. Approximately 66 percent of the funding for the HFP is federal funding while the remaining 34 percent is from the state General Fund.

## Eligibility Requirements

#### <u>Income</u>

The HFP started providing coverage to children in July 1998. The HFP currently covers children with household incomes up to 250 percent of the federal poverty level (FPL). As originally established in AB 1126, the HFP covered children ages 1 to 19 with an annual family income between 100 - 200 percent of the FPL (between \$14,652 and \$29,268 annually for a family of three) who are ineligible for no-cost Medi-Cal. The HFP covered children ages 1 – 5 from 133 – 200 percent FPL and children ages 6 – 18 from 100 –200 percent FPL. Children with incomes below the HFP minimum are income eligible for the Medi-Cal for Children (MCC) program (the Medi-Cal FPL percent programs). Children receive 12-months of coverage through the HFP before being required to re-qualify.

As part of the 1999 – 2000 State budget process, the HFP was expanded in Assembly Bill 1107 (Cedillo). AB 1107 expanded the maximum income eligibility levels for the HFP up to 250 percent of the FPL (a maximum of \$36,576 annually for a family of three). As a result of this change, the HFP also started covering children under age 1 with incomes over the Medi-Cal limit of 200 percent FPL but under the new HFP maximum of 250 percent FPL. The HFP now covers infants between birth to age 1 from 200 – 250 percent FPL, children ages 1 – 5 from 133 – 250 percent FPL, and children ages 6 – 18 from 100 – 250 percent FPL. AB 1107 also authorized the HFP to implement the use of Medi-Cal income deductions when determining eligibility for the HFP. Deductions from a family's gross income are granted under Medi-Cal, and also now under the HFP, for work expenses, child care expenses, payments of child support and alimony, and the receipt of child support or alimony. The expansion to 250 percent FPL and the use of Medi-Cal income deductions were implemented in November 1999 after the State received federal approval.

## Employer-Sponsored Coverage

The federal SCHIP program required that California structure its program such that the insurance provided through the HFP does not replace existing employer-based coverage for children. As a result, state statute established the requirement that children cannot have had employer-based coverage within 90-days prior to enrollment in the HFP. The 90-day period may be waived if the coverage ended because a family member lost the job that provided the employer-based coverage, if the employer ended benefits to all employees, if the family moved and the employer-based coverage is not available in the new area of residence, or because their COBRA coverage ended.

## Immigration and Citizenship Requirements

To qualify for the HFP, a child must be a United States (U.S.) citizen, national, or qualified legal immigrant. Under federal guidelines, immigrant children must have entered the U.S. prior to August 22, 1996 to participate in the federal SCHIP program. As a result of this federal requirement, when implemented in July 1998 the HFP did not cover children with a date of entry after August 22, 1996. During the 1999 – 2000 state budget process, AB 1107 authorized the use of state-only funds to provide coverage for 1 year to legal immigrant children who do not meet the August 22, 1996 date of entry requirement into the U.S. During the 2000-2001 State budget process, the provision of coverage to recent legal immigrant children was continued in AB 2877. Therefore, as of July 1999 the HFP has provided coverage to qualified legal immigrant children regardless of their date of entry into the United States. The HFP continues to request documentation of a child's date of entry so that the State can claim federal matching funds for children who meet the federal date of entry requirement of prior to August 22, 1996.

#### Benefits

The HFP offers comprehensive health, dental, and vision benefits. The MRMIB has contracted with 26 health plans, 5 dental plans, and 1 vision plan to provide services to HFP subscribers. Applicants may choose from plans that are available in their county of residence. Families in the HFP pay monthly premiums ranging from \$4-\$9 per child depending on family size and income, the health plan chosen, and the number of children per family that are enrolled in the program. The maximum monthly premium is \$27 per month. A co-payment of \$5 is charged for non-preventive services.

#### Application and Enrollment Process

Families interested in applying to the HFP complete the Medi-Cal for Children/Healthy Families Program mail-in application. The application is 4 pages in length and includes 8 pages of instruction. The application is available in 10 languages in addition to English: Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Lao, Spanish, Russian, and Vietnamese. Families who would like assistance in applying to the HFP may request assistance from a Certified Application Assistant (CAA). CAAs are individuals who have been trained to provide application assistance and are affiliated with an Enrollment Entity. An Enrollment Entity can be a community-based organization, school, clinic, provider, insurance agent or other organization that has

registered with the State and can be reimbursed \$50 for successful enrollments into the HFP or MCC. Applicants may also receive assistance in completing the MCC/HFP application by calling the HFP toll-free line. The HFP toll-free provides assistance in 10 languages from 8 a.m. to 8 p.m., Monday through Friday.

Along with the completed MCC/HFP application, the applicant must submit the following documents: proof of income, proof of citizenship or immigration status, proof of pregnancy (if applicable), and proof of income deductions. If the applicant does not have a copy of the birth certificate at the time of application the applicant may send it within 60 days of enrollment. If the applicant does not have proof of immigration status, the applicant may send the document within 30 days of the date of enrollment. The applicant may also submit a choice of health and dental plan, and the first month's premium payment with their application. If this information is not submitted and a child is eligible for the HFP, then the HFP contacts the applicant to request the plan choice and premium payment. Enrollment in the HFP cannot occur until the program has received the applicant's premium and plan choices.

Families submit their completed application and documentation by mail in a postage-paid envelope to the Single Point of Entry (SPE) in Sacramento. The SPE screens the applications for no-cost Medi-Cal eligibility. Applications that appear to be Medi-Cal eligible are sent via overnight mail to the appropriate county Medi-Cal office for an eligibility determination. Applications that appear to be HFP eligible are forwarded to the HFP eligibility determination unit, which is at the same location as the SPE. HFP applications are processed by an administrative vendor under contract with MRMIB. A complete HFP application is processed within 10 days, while an incomplete application is processed within 20 days. If the application is missing documentation, the HFP attempts to contact the applicant by phone to request the missing document(s). If the program cannot reach the applicant by phone, a letter is sent requesting the missing information.

The HFP administrative vendor updates the Medi-Cal Eligibility Determination System (MEDS) to indicate that a child is enrolled in the HFP. Enrollment in HFP is posted on MEDS and is indicated by aid code 9H. Data regarding the HFP eligibility determination process is stored on a system maintained by the HFP administrative vendor.

# **Confidentiality**

Confidentiality in the HFP is governed by the Information Practices Act of 1977, California Civil Code Sections 1798 et. seq. In accordance with the Information Practices Act, the HFP page of the MCC/HFP Application informs applicants how their personal information will be used. Information about persons who do not become subscribers is used only for purposes of eligibility determination and program administration. The HFP may not share information of an applicant or subscriber with other individuals or entities unless the applicant or subscriber consents or certain other strict conditions are met.

# Appendix C: Description of the Family PACT Program

One method of implementing presumptive eligibility (PE) for children would be to model it on the service delivery system operated by the Family Planning, Access, Care and Treatment (PACT) program.

#### Overview

The Family PACT program was implemented in 1997 to ensure that low-income Californians have access to the health education, counseling, and family planning services needed to reduce the likelihood of unintended pregnancy and to promote reproductive health. The program utilizes the Medi-Cal fee-for-service framework for increased efficiency, and includes both private and public sector providers. The DHS Office of Family Planning (OFP) is responsible for program policy, monitoring, and evaluation, while Medi-Cal is responsible for provider enrollment and education and claims processing.

## Eligibility Criteria

Family PACT serves clients who reside in California, are at risk of becoming pregnant or causing pregnancy, have a gross family income at or below 200% of FPL, and have no other source of health care coverage for family planning services. Medi-Cal beneficiaries who have an unmet share of cost on the date of service are eligible for Family PACT services once their share of cost is met.

## Provider Enrollment

Any Medi-Cal provider who agrees to provide the full scope of comprehensive family planning services, consistent with Family PACT standards of care, may apply for enrollment in Family PACT. Enrollees must submit an application and agreement and attend an orientation session on family planning, client eligibility, and claims payment. Additionally, Medi-Cal laboratories and pharmacies are not required to enroll, but may provide and be reimbursed for Family PACT services. All Family PACT providers bill using Medi-Cal fee-for-service procedures. Once a provider's enrollment in Family PACT has been approved, he/she will be issued a supply of pre-numbered Health Access Programs (HAP) identification cards, as well as a supply of unnumbered replacement cards to issue to clients who have lost their original HAP card.

#### Eligibility Determination Process

Family PACT providers are responsible for determining client eligibility and completing onsite enrollment of eligible clients. Clients fill out the Client Eligibility Certification (CEC) form, a two-sided one-page form that asks clients if they are receiving Medi-Cal and if they have health insurance that covers family planning services. The CEC form also asks clients to provide information such as their name, date of birth, place of birth, race/ethnicity, primary language, and family income. Clients are also requested to provide their Social Security Number, but services are still provided if they are unable to give one. No documentation is required, and providers are not allowed to ask clients for proof of family size, income or California residency.

Using the information provided on the CEC form, the provider determines a client's eligibility for Family PACT services. The provider first determines if the client is receiving Medi-Cal, then determines family size. A "Basic Family Unit" consists of the client, his/her spouse, and minor children (including stepchildren and children under guardianship) who reside with the client. The provider then compares the self-reported family income with the family size to determine if the client's income is at or below 200% FPL. If so, then the client is eligible for the Family PACT program.

# Health Programs Access (HAP) Card

The provider then immediately issues and activates a HAP card. The teal-colored plastic card is pre-printed with an identification number that does not become activated until the provider links with the administrative vendor, EDS. Providers may link with EDS in one of three ways: via their Point of Service (POS) device, by telephoning the Automated Eligibility Verification System (AEVS), or via real-time online updating on the Internet using the Family PACT Web page. POS, AEVS, and the Internet may also be used to re-certify, deactivate, update or inquire about Family PACT eligibility.

#### Re-certification Process

Once eligibility is established, clients may receive Family PACT services for one year. Providers must verify client eligibility at each visit, to ensure that no changes have occurred affecting eligibility. A verbal reaffirmation from the client that family size, income, and health insurance status have not changed suffices.

Following the first twelve months of eligibility, the client must be re-certified to continue

receiving Family PACT services. Clients complete a new CEC form and providers redetermine eligibility. Providers reactivate eligible clients' HAP cards for another twelve months.

#### Coordination with Medi-Cal

Family PACT claims processing and provider reimbursement is similar to that of Medi-Cal. Providers are given a booklet on billing tips to assist them in understanding differences in Family PACT and Medi-Cal eligibility and billing codes.

#### Fraud Issues

There are concerns with provider fraud in the Family PACT program. Much of the fraud in the program involves HAP cards and private providers. Although HAP cards are issued to individual providers and are supposed to remain with those providers, they have turned up in practices they were not assigned to. Providers must give the HAP cards to eligible clients and not retain them, although there have been some such occurrences. Additionally, there have been findings of laboratories holding onto to clients' HAP cards and fraudulently billing for services. To date, there are no concerns about fraud at public agencies, such as community health centers and clinics.

The Office of Family Planning is working to combat fraud with amended enrollment forms that stress to providers that they are responsible for the security of the HAP cards

issued to them, that the cards must remain in their possession until they are turned over to the client, and that lost or stolen HAP cards must be reported to the HAP Hotline. Additionally, AB 1107, (Chapter 146, Statutes of 1999) was enacted to help limit fraud and abuse in the Family PACT program by establishing requirements for providers wishing to enroll and for current providers wishing to continue participating in the program. This legislation amended Section 24005 of the Welfare and Institutions Code to enable the Department of Health Services (DHS) to tighten the enrollment and continuing enrollment processes, and to better identify and screen out those providers with a prior history of claiming or performance problems. OFP is in the process of drafting regulations with new application procedures for enrolling Family PACT providers. The regulations will be completed in May 2001.

# **Building on Family PACT**

If PE for MCC/HFP were implemented based on the model of the Family PACT system, there would be a number of issues to address. One of the most challenging is minimizing the opportunities for provider fraud. Although efforts are underway to tighten up provider enrollment in Family PACT, with only a number and a magnetic strip, and no identifying personal characteristics, HAP cards are easily abused. Medi-Cal access cards issued under PE for MCC/HFP would also most likely lack an imprinted name due to the need to issue the card immediately. The issue of designing a system that enables immediate access while preventing fraud would therefore need to be addressed in designing a MCC/HFP PE system. Other issues to address include how information on PE children would be transmitted to counties or HFP so that they may follow-up with families and assist them in enrolling in Medi-Cal or HFP, and how the PE eligibility Medi-Cal cards would interface with county automated systems.

# Appendix D: Presumptive Eligibility for Pregnant Women in California

California implemented its Presumptive Eligibility for Pregnant Women program in 1993 as a result of State legislation (AB 501, Chapter 1127, Statutes of 1992). The intent of the program is to encourage low-income pregnant women who are potentially eligible for Medi-Cal to start their prenatal care as early as possible. Qualified PE providers provide these women with immediate, temporary Medi-Cal coverage for prenatal services. These patients must apply for Medi-Cal by the end of the month following the month in which their PE period began.

A pregnant woman enrolls in the PE program by seeking care from a PE peri-natal provider. She completes an Application for Presumptive Eligibility (PREMED 2), on which she reports family size, family income, and dedares that she is a California resident, at her provider's office. Non-residents are not eligible for PE. If she is a California resident whose family income is under 200% FPL she is given a pregnancy test, since PE coverage is available only with a confirmed pregnancy. The cost of the initial visit and pregnancy test are covered by Medi-Cal even when the woman is not pregnant). Her provider will issue her a paper card if she is pregnant, and will also give her written instructions on how to apply for Medi-Cal.

If the woman applies for Medi-Cal within the prescribed time frame, she takes a copy of her Medi-Cal application to her PE provider, who extends her PE coverage for another sixty days. In addition to extending PE, women have an additional incentive to apply for Medi-Cal since PE will not cover the cost of a baby's birth. In order for the cost of delivery to be covered by Medi-Cal, a woman must be enrolled. If a woman does not follow up in applying for Medi-Cal before the end of the PE period, her PE will lapse, but she can still request up to three months retroactive Medi-Cal coverage for any uncovered visits if she is approved for Medi-Cal coverage. If she does not apply for Medi-Cal at all, her PE will lapse after the second month. In such cases, as well as in cases where she is determined to be ineligible for Medi-Cal, federal financial participation is still assured for the services provided during the PE period.

For administrative simplicity, PE data is not entered into the Medi-Cal Eligibility Data System (MEDS). Therefore, DHS does not currently have accurate statistics on the PE for Pregnant Women program. There is no way at present time to track whether PE clients actually enroll in the Medi-Cal program. For this reason, it is not possible to use experience with PE for pregnant women to develop an estimate of what percentage of children granted PE would follow-up to enroll in either MCC or HFP. It is also not feasible to examine the program's experience with fraud concerns since the providers who do PE are a very limited set of physicians and clinics. There have not been reports of fraud and the program has not been reviewed for fraud.

## **APPENDIX E: PROGRAM PROFILES**

#### **Cal Works and Food Stamps Programs**

# Program Description

The Califomia Work Opportunity and Responsibility to Kids (CalWORKs) program is Califomia's TANF program. CalWORKs provides temporary cash assistance to needy families with dependent children up to age 18 when one or both parents are absent, disabled, deceased, or unemployed. Unless exempt, parents are required to meet work requirements by participating in welfare-to-work activities such as subsidized and unsubsidized employment, work experience, and other training or education. Cash assistance is time-limited to not exceed 60 months. Recipients receive cash grants that vary depending on family income and family size. Recipients who are eligible for CalWORKs are automatically eligible for Medi-Cal. The 58 counties administer the CalWORKs program at the local level.

The Food Stamps program provides nutritional support to needy individuals and families. Recipients of Food Stamps who are not also receiving CalWORKs (i.e., non-assistance Food Stamps cases) are not automatically eligible for Medi-Cal, although children receiving Food Stamps are very likely to be eligible for MCC due to the similar income eligibility and immigration requirements of the two programs. Counties also administer the Food Stamps program at the local level. The California Department of Social Services (CDSS) provides statewide policy and directives for both programs.

Applicants for the CalWORKs and Food Stamps programs apply in person, or in limited cases by mail, at the County Welfare Department (CWD). Using a multi-program application, applicants may apply for one or more of the following programs: CalWORKs, Food Stamps and Medi-Cal. Applicants who wish to apply only for Food Stamps may complete a Food Stamps-only application. Applicants then undergo a screening process to determine the programs for which they may be eligible. Applicants are screened for Immediate Need (i.e., an advance on the CalWORKs grant of up to \$200 issued within 24 hours of application), Expedited Service Food Stamps (i.e., Food stamps available within 3 days of application), and Homeless Assistance (i.e., cash assistance for temporary or permanent housing for homeless CalWORKs eligibles). Once the screening is completed, an eligibility worker interviews the applicant to determine eligibility for one or more of the three programs. The determination may be conducted by a single caseworker or separate caseworkers for the different programs.

To participate in either program, households must meet income and resource eligibility standards. CalWORKs does not use federal poverty levels (FPL) to determine eligibility, however, CalWORKs income thresholds represent approximately 125% of the FPL. A Food Stamps household's gross income (i.e., income before deductions) cannot exceed 130% of FPL. Net income (gross income minus allowable deductions) cannot exceed 100% of poverty level. Under both programs, the property limit is \$2000, unless the household contains a member who is over age 60, in which case the limit is \$3000. One vehicle, with a fair market value up to \$4650, is exempted. In addition, other factors of eligibility include residency, citizenship, registration for employment, etc.

For both CalWORKs and Food Stamps, an applicant must appear for a face-to-face interview with an eligibility worker (EW) as part of the eligibility determination process. The applicant must return required verifications of income, assets and citizenship and immigration status (i.e., Social Security Number, wage stubs and award letters (SSI, UIB), bank records, vehicle registrations, birth certificates and other verification of citizenship and INS documentation), which are reviewed and used to determine ongoing eligibility. Proof of residency must be provided. Applicants must attest that there are no convicted drug felons or fleeing felons in the household. All eligible adult household members must comply with the Statewide Fingerprint Imaging System (SFIS) requirement by having a fingerprint and photo image taken.

In addition, the Food Stamps Program also requires a determination about who should be included in the Food Stamps household based on such provisions as who lives in the home, whether they purchase and prepare food separately or together, and the relationship of such persons. A time period is established within which an eligible household shall be certified to receive benefits. The certification period is for no more than 12 months, except in certain cases it may be longer (i.e., households consisting of all adult members who are elderly or disabled persons may be certified up to 24 months).

CalWORKs has 45 days to process the application, and Food Stamps has 30 days. Most counties strive to process cases as quickly as possible, and CalWORKs tries to process cases within 30 days to avoid making a separate Food Stamps eligibility determination.

Although there is no prescribed flow or sequence in state regulations, county eligibility staff must request, review and verify specific, standard eligibility conditions in order to determine whether the family is eligible for CalWORKs and/or Food Stamps. The application process is flexible by design, so that counties can take into account applicant families' schedules, ability to gather needed information, and to allow for counties' diverse operations, such as scheduling individual vs. group orientations, differing office hours, etc. CWDs must help the applicant meet all eligibility requirements in as few office-visits as possible.

Counties have different data systems, both manual and automated, to determine program eligibility and to issue notices and payments. To provide uniform information technology capability to all the counties, four consortia systems have been approved for the 58 counties. These systems will provide automated welfare eligibility for CalWORKs, Food Stamps, and Medi-Cal. The four systems are:

- ISAWS (Interim Statewide Automated Welfare System) which is currently in operation in 35 smaller counties;
- LEADER (Los Angeles Eligibility Automated Determination, Evaluation, and Reporting System) which is the system in place for Los Angeles County;
- WCDS (Welfare Case Data System) which is being used in 17 larger counties and Ventura's Legacy System will be replaced by a fully automated system called CalWIN (CalWORKs Information Network); and

• C-IV (Consortium IV), which is being designed for the four remaining counties.

Currently, each of these automated systems has an interface to the Medi-Cal Eligibility Data System (MEDS). This gives counties the ability to check MEDS to see if an individual is already enrolled in Medi-Cal or HFP and to post information on MEDS for new Medi-Cal enrollees.

# Current Linkages with MCC and HFP

If a child or adult is eligible for CalWORKs, he/she has automatic eligibility for no-cost Medi-Cal and Food Stamps, according to federal law. Although the mechanics vary among county automated systems, once an individual's CalWORKs case has been approved, Food Stamps and a Medi-Cal card (BIC) will be generated, usually simultaneously. Thus, a process is currently in place to link CalWORKs recipients to MCC.

In most counties, when a CalWORKs applicant is ineligible for CalWORKs, the application is forwarded to the appropriate EW to determine Medi-Cal eligibility. If a child is determined to be ineligible for Medi-Cal, the child is then evaluated for Medi-Cal with a share of cost. On the Notice of Action that informs the family of the outcome of their review for no-cost Medi-Cal eligibility, some counties will provide information about the HFP toll-free number so that the family can call for information and an application. It is not known how often children who are determined ineligible for CalWORKs and Medi-Cal are referred to and complete enrollment in HFP.

When a CalWORKs case is discontinued, the individual will receive a notice of action (NOA) explaining the reason for the discontinuance. All CalWORKs termination NOAs include a message that Medi-Cal benefits will continue. Included with the NOA is a short form that briefly describes the Transitional Medi-Cal (TMC) program requirements as well as information on other forms of extended Medi-Cal. This form is designed for recipients to complete and return to request TMC benefits or other health coverage. CalWORKs cases that are discontinued are evaluated to determine whether a redetermination is needed, or whether the recipient will remain in the 1931(b) program. Due to recently enacted legislation, this process is being streamlined so that, by July 1, 2002, it will be transparent to the recipient in most cases.

Efforts are underway to improve the process for ensuring that all former CalWORKs recipients continue to receive Medi-Cal as long as they remain eligible. During implementation of 1931b, counties have established procedures to ensure former CalWORKs recipients were enrolled in 1931b. Examples include: hiring a full time applicant assistant in completing forms, reviewing all terminations within the office to ensure that Medi-Cal is not lost inappropriately, and issuing monthly Medi-Cal program updates to staff which contain eligibility reminders and important news and changes. Similar processes may be utilized to ensure enrollment in Medi-Cal and HFP. Another suggested strategy is to have Welfare-to-Work staff assist individuals they serve in completing the Medi-Cal application.

<sup>&</sup>lt;sup>43</sup> DHS and MRMIB are currently considering options to improve the process for the sharing of information between Medi-Cal and HFP so that children who are determined to be ineligible for Medi-Cal are referred appropriately and quickly to HFP. See Chapter 2 for further details.

Alternatively, less attention has been given to the linkages between Food Stamps and Medi-Cal in cases where Food Stamps recipients are not also receiving CalWORKs. These individuals, some of whom may have completed the Food Stamps-only application, have no automatic eligibility for Medi-Cal and may not be getting a referral to Medi-Cal or Healthy Families.

# Uninsured Children Potentially Reached Through the Program

CalWORKs participants are automatically eligible to receive no-cost Medi-Cal. As of August 2000, there were 1,127,871 children served through CalWORKs. Therefore, all of these children should be enrolled in Medi-Cal. As of April 2001, a data match is underway at the State level to confirm this. While there is not a need to create a *new* process for linking CalWORKs applicants and recipients to Medi-Cal, there is room to examine and, if necessary, improve the existing process of referring persons who are ineligible for CalWORKs and Medi-Cal to HFP.

If a child is eligible for non-assistance Food Stamps (i.e., not receiving CalWORKs), there is no categorical eligibility for MCC or HFP. However, based on income levels and other eligibility criteria, all children who receive non-assistance Food Stamps would be eligible for one of the two programs. In federal fiscal year (FFY) 1999, there were 442,710 children under the age of 21 in non-assisted Food Stamps households. State administrative data indicate that, as of February 2001, there were about 46,000 children receiving non-assistance Food Stamps who were not enrolled in either MCC or HFP.

Efforts have been initiated at the State level to encourage counties to follow up with families who are receiving Food Stamps but whose children are not enrolled in MCC or HFP to inform them of their children's eligibility for MCC or HFP. The activities currently underway build upon prior efforts made by CDSS and DHS in 1999 to identify children who were eligible for Food Stamps but were not covered by MCC. A data match revealed then that approximately 92,000 children on Food Stamps were not receiving MCC. A letter was issued to each CWD that indicated the number of affected children in that county and offered counties the opportunity to receive the names and addresses of these children for the purpose of contacting their families. Included in the letter were camera-ready copies of MCC outreach flyers. Forty-two counties and multiple agencies in those counties, including legal services agencies, public health agencies, mental health agencies, and other outreach programs, requested information on these children and contacted their families. As a result of this effort, the number of eligible but uninsured children receiving non-assistance Food Stamps was reduced by almost 50,000. CDSS, DHS, and MRMIB are initiating another outreach effort to reach the remaining uninsured children who are receiving Food Stamps. This effort will become a routine process of collaboration between CDSS,DHS, and MRMIB.

#### Possibilities for Implementing the Options

These options focus on Food Stamps since there is a process in place to streamline enrollment between CalWORKs and Medi-Cal.

### Option A. Establish or enhance referral processes between other programs and MCC/HFP

A referral process already exists between CalWORKs, Food Stamps and Medi-Cal because there is a common application for these programs. However, when a family applies for non-assistance Food Stamps using a Food Stamps-only application form, there is no automatic direct referral to other services/programs.

In many counties, Food Stamps-only applicants are required to attend an orientation session before the face-to-face interview in order to provide information on all programs offered through the department. During the interview, clients are asked about the programs for which they wish to apply, and their application would be handled accordingly. If, during the interview, it becomes apparent that the applicant would be eligible for another program, information on that program is offered. The client may then be referred for a separate eligibility determination for Medi-Cal and Healthy Families.

A possible enhancement to the process in counties that are not already doing this would be for the Food Stamps EW to check MEDS to see if the applicant is receiving Medi-Cal or HFP. If not, the EW could provide the applicant with information on Medi-Cal and/or HFP and/or refer the person to a Medi-Cal EW. In addition, information could be mailed to existing non-assistance Food Stamps households to inform them of how they could get more information on these programs.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

The existence of the common application for CalWORKs, Food Stamps, and Medi-Cal means that families are already getting onsite assistance in applying for MCC if they use that application.

Some counties make the joint MCC/HFP application available on site and will accept the forms and forward them to the HFP SPE for processing. However, rarely do the counties provide assistance to families in filling out the joint MCC/HFP application. In some cases, counties have done training with local community based organizations (CBOs) so that the CBOs can assist the families in completing the application instead. A promising approach would be to have counties provide on-site assistance with the joint MCC/HFP application.

In some counties, EWs who handle non-assistance Food Stamps cases are only trained to provide assistance with Food Stamps. In order for non-assistance Food Stamps workers to assist with an application for MCC or HFP, they would need additional training. It would also take additional interview time for workers to provide assistance and would result in increased county administrative costs.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

Applicants for CalWORKs, Food Stamps, and Medi-Cal currently complete a common multi-program paper application. In addition, there is a Food Stamps only application. It is possible to modify both applications so that either could be used to apply for Medi-Cal and HFP as well. However, this option is not desirable because it would lengthen both applications, increase complexity which could lead to errors, increase the time families are required to spend in the welfare office, and will require reprogramming of the eligibility automated systems.

A common automated application is not seen as feasible at this time because there is no common automated application or eligibility system used throughout the State for CalWORKs and Food Stamps. However, several counties do have an automated application and eligibility system. Los Angeles County, using LEADER, and counties, using ISAWS, have automated systems. In order for a statewide common system to be used, extensive programming would be required at the county level. However, crosscounty automated sharing would not be possible because the four consortia are currently unable to communicate with one another. Once all four consortia are automated, which is projected to occur in less than five years, each system could handle an automated, paperless joint application. The CalServe system is being developed to serve as a clearinghouse for the four automated systems and will allow the systems to share information.

## Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option is promising. Because counties administer both the Food Stamps and Medi-Cal programs, much of the sharing of information can be done within local county welfare departments, without requiring information to be transmitted to SPE. Following the approach used by DSS, it is possible for counties to conduct periodic matches between Food Stamps and MEDS data to identify children receiving Food Stamps who are not receiving MCC or HFP. For each child, the county could use the Food Stamps case file to determine whether the child qualifies for MCC or likely qualifies for HFP, since the HFP determination is not made at the county level. The county could then seek parental consent to use information contained within the child's Food Stamps case file to enroll the child into MCC or send the information to HFP if the child is not eligible for MCC. This consent could be obtained during an intake interview or re-determination visit, or through the mail.

Most of the eligibility information and verifications required for MCC/HFP would already be captured in the Food Stamps case file.<sup>44</sup> With the permission of the household, counties can use the information already contained in the Food Stamps files to determine Medi-Cal eligibility, with perhaps a few additional items of information being asked of the families. In determining eligibility for either MCC or HFP, the counties and

<sup>&</sup>lt;sup>44</sup> Some information may not be available or may be incomplete in the Food Stamps case file if a person were to apply using the Food Stamps-only application.

HFP will need to re-examine the family's household composition and income information due to eligibility differences between Food Stamps and MCC/HFP.

Food Stamps computes household composition differently than does MCC/HFP, which means that some household members, and their income, who are counted when determining Food Stamps eligibility would not be counted by MCC/HFP. For example, Food Stamps requires persons who are not related to a child but who purchase and prepare meals with that child to be included in the household composition. MCC/HFP would not count these unrelated persons or their income when determining MCC/HFP eligibility. Currently, state and county data systems do not track Food Stamps household members' relationships to each other, so a manual review of case files would be necessary to determine those relationships prior to determining MCC/HFP eligibility.

Food Stamps and MCC/HFP both allow income deductions. However, these deductions are not the same. While both programs deduct child care costs and child support paid, Food Stamps also allows the following income deductions: 20% of earned income, self employment expenses, a standard deduction of \$134 for all persons with any source of income, excess medical deduction, homeless shelter deduction of \$143, excess shelter deduction of \$300 or \$340, Standard Utility Allowance (SUA) of \$203 or utility costs for households that choose to deduct actual utility costs instead of SUA. MCC/HFP also apply a standard work expense deduction of \$90 per person who is employed or is receiving State Disability Insurance or Workers Compensation, and a deduction in the amount of any alimony paid. Due to these differences, the net income for Food Stamps may be different than net income for MCC/HFP.

A process can be developed for counties to transmit information to HFP on children whose family income appears to qualify them for HFP. Since most of these children receiving non-assistance Food Stamps will most likely qualify for MCC due to Food Stamps eligibility levels, it may be preferable that Food Stamps children who have been determined ineligible for MCC be referred to HFP via the processes DHS and MRMIB are considering currently to improve information sharing between MCC and HFP. DHS and MRMIB are undertaking efforts to improve this process. Alternatively, Food Stamps could instead send its household composition information to SPE, which may then need to follow-up with families to obtain information about household members' relationships to the child and reconfigure household income information. There are a number of challenges with counties submitting key data elements to SPE electronically, due to differences between Food Stamps and MCC/HFP eligibility requirements and the limitations of the welfare data systems currently in place. For example, some county data systems may be able to differentiate between deductions, which would allow counties to transmit information on specific income deductions to SPE; this is not possible in other counties.

### Option E. Grant presumptive eligibility for MCC and/or HFP

Currently, counties have 45 days to determine MCC eligibility and 30 days to determine Food Stamps eligibility. Allowing Food Stamps EWs to grant presumptive eligibility for MCC could speed children's access to health care during this time period. In this case, the granting of presumptive eligibility would function more like an "accelerated"

enrollment," because screening would be conducted by county EWs, who are already using an accepted screening logic.

However, since presumptive eligibility may not result in actual enrollment, and counties have access to Food Stamps case files for use in determining eligibility for Medi-Cal, pursuing Option D may be favorable. Another approach would be to implement Options D and E simultaneously. It would be possible to grant presumptive eligibility to children who have a Medi-Cal/HFP application pending by virtue of parental agreement to allow the county to use Food Stamps case file information for the Medi-Cal eligibility determination or to forward the information to HFP.

### Lessons Learned from Other States and Counties in California

Los Angeles County conducted Medi-Cal outreach for Food Stamps families in 1999. The county mailed out over 27,000 flyers to families thought to be receiving Food Stamps but not enrolled in Medi-Cal to encourage them to apply for health coverage benefits. Due to an error in the initial data used to mail the flyers, many flyers were sent to households already receiving Medi-Cal. As of January 31, 2000, 4,132 families had responded to the flyer. Nearly 3,000 were already receiving Medi-Cal (some were members of Medi-Cal managed care plans but were confused and thought "Medi-Cal" was a different program). Of the remaining respondents, 1,059 were subsequently enrolled in Medi-Cal, and 155 were found to be ineligible for Medi-Cal.

### Snapshot of Options

Food Stamps: A, B, D, E

### Women, Infants and Children (WIC) Program

### **Program Description**

The Women, Infants and Children (WIC) Supplemental Nutrition Program is a supplemental nutrition program for pregnant, breastfeeding, and postpartum women and children under age 5 who have a nutritional risk, who live in households at or below 185 percent of FPL, and who are California residents. The goal of the WIC program is to decrease the risk of poor birth outcomes and to improve the health of participants during critical times of growth and development. To meet this goal, WIC provides participants with nutrition education, breastfeeding support, medical care referrals, and checks to purchase specific nutritious foods. Almost one million families, including nearly half of all infants born in California, participate in WIC. The program serves approximately 750,000 children per month.

WIC receives federal funding from the U.S. Department of Agriculture. The program is administered by 81 local county and private non-profit agencies that offer services at over 650 WIC centers in all 58 counties.

Parents and legal guardians can apply for WIC services for their children. Local WIC agency staff screen applicants in person or on the phone by using a consistent set of questions contained within WIC's Integrated Statewide Information System (ISIS). The first question asked of the applicant is whether someone in the family is enrolled in CalWORKs, Food Stamps or Medi-Cal. All children and women who are enrolled in CalWORKs and/or Food Stamps and most who receive Medi-Cal are automatically income eligible for WIC. WIC staff uses ISIS to interface with the Medi-Cal Eligibility Data System (MEDS) to determine whether an applicant is enrolled in these programs. Other than this general question pertaining to the family as a whole, there are no specific questions pertaining to the family's source of health insurance.

Local agency staff schedule an enrollment appointment for applicants who appear to be eligible for WIC based on their responses to the screening questions. The application process must be completed in person at a local WIC office. The enrollment appointment includes eligibility determination, nutrition assessment and counseling, explanation of the use of food instruments, and review of participant rights and responsibilities. Eligible applicants receive food instruments on the same day as their in-person enrollment appointment. Overall, the intake appointment takes about one hour.

At the enrollment appointment, applicants must provide written documentation of income eligibility (e.g. pay stub), although they are permitted to self-declare income in certain circumstances (i.e., fire, disaster). The WIC program does not verify income information, other than through the income documentation provided, unless fraud is suspected. For applicants who are currently enrolled in Medi-Cal, CalWORKs or the Food Stamps Program, WIC staff again uses ISIS to link to MEDS to confirm adjunctive eligibility in WIC due to enrollment in CalWORKs, Food Stamps or the appropriate form of Medi-Cal. Alternatively, applicants may provide written documentation to prove they are enrolled in one or more of these programs. WIC does not ask families about citizenship status. While Social Security Numbers (SSNs) are requested, they are not required for WIC eligibility. About 25 percent of the participants provide a SSN.

All information required for determining and documenting WIC eligibility is entered in ISIS. In addition, each participant's ISIS record includes information about health and nutrition status and about the WIC services each person receives. WIC staff can search ISIS for information about a WIC participant in several ways – 11 digit ISIS individual ID number, 11 digit ISIS family ID number, SSN, Medi-Cal number, CA ID/driver's license, or a combination of name, date of birth, or mother's first name. Information stored in ISIS that pertains to an individual WIC participant can be shared with other health and social services agencies only with the written consent of the participant.

For applicants who meet the income eligibility requirements, WIC staff completes a health and nutrition assessment. This entails collecting and evaluating basic health information (height/length, weight and a blood test for iron-deficiency anemia) and obtaining information about medical conditions and dietary intake. Applicants are asked to provide this basic health information from well-child or pre/post-natal medical appointments. Once enrolled, participants are required to provide repeat health information at regular intervals. WIC uses this health information for assessments of continued eligibility and to provide effective follow-up and nutrition counseling. WIC staff will weigh and measure children in the WIC office if basic health information is needed and the children are not due for a health check-up. Most infants are certified for WIC eligibility until their first birthday, and children are certified every 6 months.

### Current Linkages to MCC/HFP

Both through on-going activities at local WIC offices throughout the state and through one-time statewide and local projects, WIC staff have demonstrated their commitment to improving access to health care for their participants.

WIC Branch staff conducted a recent survey of the 81 local WIC programs regarding current collaboration with MCC/HFP. With 65 (or 79 percent) of 81 local agencies responding, it is evident that many WIC sites are providing referrals to MCC/HFP and providing education and on-site assistance with applications.

### Examples include:

- Six local agencies (9 percent of respondents) use their own staff to assist WIC participants with MCC/HFP applications. These programs receive funding from HFP to conduct these activities (i.e., WIC funds are not used to enroll participants in these programs).
- Twenty-six agencies (40 percent of respondents) provide space at a total of 83 sites for a CAA to assist with MCC/HFP applications. The average number of hours that a CAA is available is 100 per month, varying from just 4 to over 540 hours per month per program.
- Five agencies track the number of participants that are referred to MCC/HFP and/or receive application assistance.
- Fifty-eight agencies (89 percent of respondents) provide pamphlets and applications for participants to enroll in MCC/HFP.

Other MCC/HFP referral activities described by the local WIC agencies include:

- HFP provision of training to WIC staff.
- Featuring HFP information in WIC handouts.
- The county or non-profit agency sponsoring the individual WIC local agency has a system to assist WIC participants and others in applying for HFP.

In addition to the local referral activities and on-site assistance, there are a number of other activities WIC has initiated to promote children's access to health care.

For example, in December 1998, DHS implemented the short-term "Give Your Child the Gift of Health" campaign to educate families about HFP. The WIC program utilized the ISIS database to access the names and addresses of families with children not enrolled in MCC. The list was further tailored to specify those families whose income level qualified them for HFP, and the preferred language spoken at home. The resulting set of mailing labels enabled DHS staff to send a letter to over 150,000 families, informing them about HFP and encouraging them to call or visit their local WIC office to speak with a CAA about completing a MCC/HFP application. The campaign also included providing local WIC offices with display banners and buttons for staff to wear as an information campaign for WIC participants.

It was not possible to determine how effort this resulted in successful MCC/HFP enrollments; however, WIC offices experienced a noticeable increase in the number of inquiries about health care coverage from WIC families. It was the first time local WIC staff had actively worked together with CAAs to connect families with health care, and the initiative encouraged local Medi-Cal and WIC program staff to establish several models for collaboration that continue.

In addition, the California Endowment funded the California WIC Association (CWA), the non-profit association of California's local WIC directors, to participate in a collaborative year-long effort designed to close the prenatal care gaps for immigrant women in three targeted areas: Los Angeles, San Diego, and Riverside Counties. The goal of the grant is to use the WIC setting to increase immigrant enrollment in prenatal care and the Medi-Cal program.

In another effort, the California WIC community just completed a yearlong strategic planning process focusing, in part, on the need to improve customer service in local WIC offices, including referrals to health care programs. One specific goal of the strategic planning process has been to identify sources of additional funding to increase WIC participants' access to, participation in, and utilization of health care, food, housing, employment, and/or other empowement programs.

Examples of activities individual WIC programs may pursue include:

- Screening and referring WIC participants to Medi-Cal, HFP and the Food Stamps Program; and
- Increasing the number of Medi-Cal eligibility workers out-stationed in WIC sites.

Also as part of the strategic planning process and in collaboration with California WIC Association, California WIC has a planning initiative to determine how WIC can further enhance the services it provides participants within the community using funds from other sources. This planning initiative is called "WIC Plus" and is partially supported with foundation funding. Several WIC agencies have experience in providing enhanced services using funds from sources other than WIC (e.g. immunizations, literacy, workforce readiness, and smoking cess ation).

Finally, the WIC Program has added information about MCC/HFP to its statewide toll-free phone number (1-888-WIC-WORKS).

### Uninsured Children Potentially Reached Through the Program

The WIC Program serves approximately 750,000 infants and children each month. According to ISIS data, about 60 percent of these participants, or 465,000, are enrolled in Medi-Cal. Since WIC does not currently collect information on source of payment for health care, there is no easy way to determine how many of the remaining non-Medi-Cal WIC participants are enrolled in HFP. However, a data match between ISIS and MEDS at the State level that could shed light on this issue is underway.

Since the income eligibility for WIC requires family income to be less than 185 percent of poverty, all WIC infants up to age 1 are very likely to be income eligible for MCC and all other children in WIC ages 1-5 are very likely to be income eligible for either MCC or HFP, depending on family income. As noted previously, WIC does not request information about citizenship and immigration status and is therefore unable to assess whether these participants would meet the MCC/HFP citizenship and immigration requirements.

#### Potential for Implementing the Options

### Option A: Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. In WIC offices, this process already happens as part of normal referral procedures. WIC staff provides participants referrals and applications to other programs during their enrollment appointment and follow-up education sessions. Referral information and applications are also available in most WIC offices as waiting room displays. Participants can ask staff for general information or simple instructions on the processes for enrolling in other programs. To facilitate this referral process and more easily identify uninsured families, WIC could make an inquiry about health insurance a regular part of the intake process. WIC is in the process of adding a question to the ISIS database for this purpose. The current question about Medi-Cal receipt is too narrow to identify whether families have a source of insurance. Adding such a question to the ISIS database requires reprogramming the system. This enhancement should be in effect by the end of 2001.

To the extent that WIC staff is already doing this level of referral in most WIC offices, this option provides the service with the least amount of additional staff time, but is not likely to be noticeably different from current practice in terms of overall impact. Use of a

standard referral form and an up-to-date listing of CAAs in the local area would strengthen the model. WIC staff can be trained to answer basic questions about MCC/HFP, and some resources may need to be devoted to this on at least an annual basis. There would be minimal fiscal impact, because the referral would occur along with the other program referrals that WIC staff makes as a part of their regular duties.

### Option B: Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. Some WIC local agencies are already providing onsite application assistance and eligibility screening for MCC/HFP. These efforts could be enhanced or extended to other WIC sites. WIC sites may be a promising location for the use of the Health-e-App. Federal WIC funds cannot be used for any other purposes than WIC functions so additional non-WIC funding would be needed for WIC agencies to provide on-site application assistance for MCC/HFP.

# Option C: Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

A common paper application is not feasible for the WIC program since WIC has completely automated its application process. However, it might be feasible to develop a common automated application process with MCC/HFP since WIC's automated ISIS system is statewide. The development of a common automated application would require extensive programming and systems changes, especially due to the different consortia in place in the counties.

## Option D: Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option is promising. The income requirements used by the WIC program overlap those of the MCC/HFP programs. WIC serves children up to age five with family incomes not exceeding 185% FPL. All WIC children up to age one are very likely to be income eligible for MCC. Children ages one through five are very likely to be income eligible for MCC or HFP, depending upon family income level.

As part of the intake process, WIC agencies ask applicants whether they are currently receiving Medi-Cal and can link to the MEDS system to confirm the applicant's report. In addition, WIC staff at the state or local level can search the ISIS system and link to MEDS to identify existing participants of WIC who are not receiving MCC or HFP. For those children that are identified as not being covered by MCC or HFP, WIC can inquire whether they have another source of health insurance and if the parent would like to grant consent for their income and other eligibility information to be sent to MCC/HFP for eligibility determination.

However, there are differences between WIC and MCC/HFP that would make it necessary for MCC/HFP to recalibrate household and income information received from WIC to match MCC/HFP guidelines. One challenge is that while WIC uses gross income when determining family income level, MCC/HFP uses net income after

applying income deductions. In addition, WIC counts ten types of income when determining a family's income level that MCC/HFP do not. Second, WIC's household composition determination is done much differently than in MCC/HFP. For example, WIC counts CalWORKs and SSI/SSP recipients as household members while MCC/HFP excludes them.

While MCC/HFP would have to perform this recalibration, this option is still very feasible. WIC estimates that this would not be a high-cost option, and would add only 5 minutes to each WIC intake interview to obtain the information about household composition and income needed by MCC/HFP. WIC could provide all of the key data elements MCC/HFP would need to initiate a health coverage application on a child's behalf. WIC staff at the state or local level could extract the eligibility information from ISIS, either a one-time on-line extraction or by batch, and send the information to MCC/HFP. A batch process would be cheaper than on-line real time data exchanges. The batch process would require a data extract from ISIS and the creation of a data file. SPE would sort and use this data to initiate health coverage applications.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This option is promising. Federal law specifies that WIC agencies are qualified entities for the purpose of determining presumptive eligibility. At the state level, WIC has expressed interest and enthusiasm about the potential for granting presumptive eligibility.

### Lessons from Other States or Counties in California

The **Ohio WIC** program is utilizing a combined paper-based program application. When the form is completed in the WIC office, it is considered an expedited enrollment allowing the participant 60 days of eligibility while the different programs participating in this common application collect all other needed information for permanent eligibility. The form includes a confidentiality statement that the participant must read and sign before staff can forward the information to the other programs. The form includes a citizenship question that is clearly designated as optional. In fact, WIC staff ignores the question and forwards the form to allow the programs that require such information to pursue the response. The system works well with few barriers. However, Ohio would like to move beyond a paper-based system to utilize electronic information exchange.

#### **Snapshot of Options**

A, B, C (automated only), D, E

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<sup>&</sup>lt;sup>45</sup> WIC is currently pursuing the development of shared electronic card options (e.g. card with a computer chip) with other health programs. Card technology with a dient focused approach could be used to: retain information on benefits, service history, upcoming appointments and health and nutrition recommendations; facilitate referrals and streamline applications; allow the participant to control the card and share health and eligibility data between programs or providers as appropriate; coordinate service delivery and follow-up; detect/eliminate duplicate services; and dispense benefits. This type of technology would eliminate most confidentiality concerns by putting the dient in control. Clients act as "case managers" to control access to the data on their card.

### Child Health and Disability Prevention Program (CHDP)

### **Program Description**

The Child Health and Disability Prevention Program (CHDP) is a State program that began in the mid 1970's. The program included the screening benefits of the Early and Periodic Screening Diagnosis and Treatment program (EPSDT) at the Federal level. CHDP provides early, periodic screening for three populations: children up to age 21 who receive Medi-Cal, children ages 0 to 19 with family incomes up to 200 percent of FPL who do not receive Medi-Cal, and children enrolled in Head Start or State Preschool. Currently, over 2 million children are screened annually through CHDP, one million of whom are children without MCC benefits and are income-eligible for CHDP services.<sup>46</sup>

Each local health jurisdiction (3 cities and 58 counties) has a local CHDP program that is responsible for enrolling providers into a provider network. Providers, most of whom are Medi-Cal providers, must meet guidelines similar to guidelines for Medi-Cal to become part of the network. These guidelines include having pediatric experience and equipment, and having sample records screened. There are approximately 4,500 CHDP providers statewide.

Children ages 0 to 19 years with family incomes up to 200 percent of FPL who do not receive Medi-Cal must qualify for CHDP at the time of each health examination. There is no ongoing eligibility through CHDP for children without MCC. Providers verify children's eligibility based on information that is self-reported by the family on the CHDP Eligibility Information Form (DHS 4073). The parent completes this one-page form at the provider's office at the CHDP services. The DHS 4073 contains family size and income information. DHS requires the DHS 4073 be attached to the Confidential Screening/Billing Report (PM 160). The PM 160 documents the CHDP services that were provided and serves as a reporting and billing form. It contains contact information, the child's date of birth, CHDP provider's name, and reports the services the child received. The CHDP provider mails a copy of the PM 160 to the CHDP program in their local health jurisdiction. Some local programs may use data processing systems to store the information for children with needs identified during the health exam, although most programs keep paper-based records. The CHDP provider mails the original copy of the PM 160 with the original copy of the DHS 4073 to Electronic Data Systems (EDS), and EDS reimburses the providers for the CHDP visit if the child did not have MCC or if the child was in Fee-for-Service Medi-Cal.41 EDS key data enters selected information from both forms into an automated data system. Family contact information, however, is not currently maintained in this system.

### Current Linkages to MCC/HFP

Currently, when a CHDP provider identifies a health problem and the child is on Medi-Cal Fee for Service, Medi-Cal will pay for the treatment and the child may receive treatment from the CHDP provider. A child enrolled in Medi-Cal Managed Care or HFP

<sup>&</sup>lt;sup>46</sup> This could be a duplicated count of children.

<sup>&</sup>lt;sup>47</sup> EDS is also the current SPE contractor for HFP.

will need to use services through his or her health plan, which may or may not be delivered by the CHDP provider depending on the health plan's provider network. However, when a child is not enrolled in Medi-Cal or HFP, it can be difficult for the child to obtain treatment. Consequently, there is an incentive for CHDP programs and providers to help children get enrolled into MCC or HFP.

Local CHDP programs refer uninsured children to MCC/HFP; however, it is not known to what extent local programs follow up with families to assure their enrollment. CHDP providers are encouraged to refer CHDP-eligible children and their families to MCC/HFP. It is not known how often providers refer families to health care coverage.

### Uninsured Children Potentially Reached Through Program

There are approximately one million non-Medi-Cal children served through CHDP annually. Many children receiving CHDP services are very likely income eligible for MCC or HFP since the income threshold for CHDP services is 200 percent of FPL, which is below the maximum eligibility level for HFP. It is unknown how many children served through CHDP are likely to be eligible for MCC versus HFP.

#### Possibilities for Implementing the Options

### Option A. Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. When a child receiving CHDP services is found not to be on MCC or HFP per a parent's self-dedaration, the local CHDP program or the provider should refer the family to a CAA, give them a joint MCC/HFP application, or provide other information on how to apply for MCC/HFP. This process could be enhanced if every CHDP provider referred families to MCC/HFP. CHDP has expressed concerns, however, that some providers may not like this requirement, and may potentially elect to discontinue providing CHDP services. CHDP providers could obtain parental consent to send the family's contact information directly to MCC/HFP for follow-up or give families the option not to have the information transferred. The CHDP Eligibility Information form could be revised to request this permission from participants during the CHDP visit.

### Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. With additional resources, CHDP providers and local programs could provide families with education and on-site assistance with MCC/HFP applications. Some CHDP providers already have office staff trained as CAAs, who assist applicants with the MCC/HFP application. The MCC/HFP outreach campaign could work to encourage more CHDP providers to send a staff member to CAA training, or establish relationships with CAAs, who may come into their office to assist clients or accept referrals from CHDP providers.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

The CHDP Eligibility Information form is one page in length and would need to become longer to collect the information necessary to determine eligibility for MCC/HFP. Due to the fact that parents must complete the CHDP Eligibility Information form at the time of each health exam, a common paper-based or automated application is not seen as feasible. The existence of a longer, more complex form would likely discourage parents from seeking preventive care for their children through CHDP.

### Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option may be viable with changes to the existing information systems. The income requirements for non Medi-Cal CHDP are similar to those of MCC and HFP. CHDP covers children from birth to age 19 whose family incomes do not exceed 200 percent of FPL. This level is within MCC/HFP levels, with most children from birth to age one very likely to be income-eligible for MCC, and children ages one to 19 very likely to be eligible for either MCC or HFP, based upon their family's income level.

EDS is not currently under contract to enter family contact information into the system for CHDP billing/reporting purposes. Local CHDP programs do not routinely maintain contact information. EDS has the ability to transmit information to Single Point of Entry (SPE), but this information would not include an address or phone number to contact the family. Without contact information, SPE would be unable to initiate a MCC/HFP application on behalf of a non-Medi-Cal CHDP child or follow up with the family. System capacity could be enhanced if EDS were to input the contact information into the system. DHS would need to negotiate a contract amendment with the vendor and pay for the additional service.

Even if system capacity is built to allow contact information to be entered and shared with SPE, CHDP forms do not request all of the information required for MCC/HFP eligibility determination. CHDP does not collect or maintain information on immigration status, and has little information on household composition. Differences between the CHDP and MCC/HFP would make it necessary for MCC and HFP to conduct extensive follow-up to obtain the information needed for MCC/HFP eligibility determination. CHDP does not require documentation of income while MCC/HFP does. MCC/HFP do not count approximately twenty-three types of income when determining a family's income level, but in CHDP, the parents self-declare their income. Finally, whereas MCC/HFP have specific rules about which persons living in a child's home are considered when determining household composition, CHDP asks parents to state how many people are in their family and accepts this as the household size. For these reasons, even if eligibility information is shared with MCC/HFP, it would be treated as a referral for follow-up, instead of initiating an application.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This option is promising. It is anticipated that many CHDP providers will be interested in granting presumptive eligibility for MCC or HFP if they can then provide treatment services to those children with needs identified during the health examination.

#### Lessons From Other States and Counties in California

In 1998, the **Sonoma County CHDP** program received funding from the California Health Care Foundation to disseminate basic information about all health coverage programs available to children including MCC, HFP, California Kids, and Kaiser Cares for Kids. CHDP outreach workers were equipped with flyers and basic information on all programs and referral resources. Based on the information provided by families, outreach workers give families referrals to the most appropriate health insurance program. CHDP staff was trained to assist with applications, so that they could either help the family directly or refer the family to an application assistant. In addition, CHDP staff informs CHDP providers about where they can refer families for assistance. Findings from the first 18 months of the project indicate that many families who appeared to be eligible for MCC were reticent to apply due to previous negative experiences with or misconceptions about MCC. Enrollment into programs was effective when the outreach worker was an experienced CAA and provided active assistance until enrollment was completed.

The **Santa Cruz County CHDP** program implemented a procedure for follow-up of children with dental problems and/or referrals for dental services that maximizes the enrollment of eligible children into health care coverage. Local CHDP program staff use their local access to the MEDS files to determine if a child has ever been enrolled in MCC or HFP. Staff sends the family a letter acknowledging their history with health care coverage and includes a HFP/MCC joint application. They recheck the MEDS file in 60 days to determine if the child/family has been reestablished with Medi-Cal or HFP. If the family has reestablished their Medi-Cal, CHDP staff mails the family a list of the dental resources that accept Medi-Cal. If the family has not reestablished their health care coverage, the staff sends a reminder that an application had been mailed and invites the family to apply and/or ask for assistance if needed. With this approach, approximately 40 percent of the families reestablish their connection to MCC/HFP.

#### Snapshot of Options

A, B, D (limited), E

### National School Lunch Program (NSLP)<sup>48</sup>

### **Program Description**

The United States Department of Agriculture's (USDA) National School Lunch, School Breakfast, and Special Milk Programs provide reimbursement to non-profit "sponsors" (public/private schools, residential child care centers, etc.), who serve meals/milk to children in kindergarten through grade twelve. This profile will focus only on the National School Lunch Program (NSLP).

Reimbursement for the NSLP is based upon the eligibility of each child, which is determined by family household size and income, and established through an annual application process for the program. USDA reimburses schools at three different rates for the meals that are served: free meals are reimbursed at the highest rate, followed by reduced price meals, and finally paid meals.

In California, the Department of Education (CDE) administers the NSLP. In April of each year, CDE disseminates prototypes of NSLP applications and letters to households, along with federal Income Eligibility Guidelines (IEG) to the approximately 1,000 school districts in California. There are four English-language and two Spanish-language prototype applications sent out by CDE. School districts are encouraged to use these prototypes, but they may design their own format, as long as the application contains the same content and is approved by CDE prior to use. At this time, CDE does not allow for any NSLP applications to contain eligibility questions that do not pertain to the school food service benefits for which the family is applying.

Some school districts and schools do not distribute and collect NSLP applications annually. There are two main reasons why children may not submit a written NSLP application:

- 1. As authorized by USDA, a school district may use one of three alternative claiming provisions for reimbursement of meals. Approximately 20% of the 1,000 California school districts use alternative claiming. Under these methods, schools may not have to collect eligibility applications from children every year.
- 2. Some schools use a method called "direct certification" to expedite enrollment into NSLP for children served through CalWORKs, Food Stamps, or the Food Distribution Program on Indian Reservations (FDPIR). Direct certification is a process by which data from county CalWORKs or Food Stamps files is compared with school enrollment data to determine which students are receiving CalWORKs or Food Stamps benefits, and thus are categorically eligible for free meals. Households are then notified of their children's eligibility and are not required to

<sup>49</sup> However, there are instances in which schools would not distribute and collect school lunch applications annually.

<sup>&</sup>lt;sup>48</sup> This profile focuses specifically on the NSLP although it is possible to implement MCC/HFP outreach and education efforts through other school-based approaches with the assistance of other school and non-school personnel. These other approaches are described in the profile on the School Health Connections program.

submit an application for those children. Of the 1055 school districts in California, 265 school districts use the direct certification method.

In schools that do not participate in direct certification or use alternative claiming, NSLP applications are sent home with children for parents to complete. The application requests that parents provide information about their household size and income and return it to their child's school. Thus, income is self-dedared by the parent. Parents are then notified of their child's eligibility within 10 days. Children who receive CalWORKs, Food Stamps, or Food Distribution Program on Indian Reservations benefits are categorically eligible for free meals under the NSLP. Income verification is required on a sample (3% of total applications for "Random" sampling; lesser of 1% or 1,000 of the total applications for "Focused" sampling; or 100% of the total number) of applications received by each school district. The sampling is done annually, based on applications on file on October 31. Verification must be completed by December 15.

### Current Linkages to MCC/HFP

Currently, there is no formal linkage specifically between California's NSLP and MCC/HFP, though there are efforts underway to promote school-based MCC/HFP outreach and education. DHS' School Health Connections is the primary effort led at the State level (this program is described in another profile). One of many strategies used by many schools is to distribute MCC/HFP information and/or applications with NSLP applications and children's emergency cards and during back-to-school nights and other special school-sponsored events.

### Uninsured Children Potentially Reached through the Program

The federal income guidelines for free and reduced price meals provided through the NSLP closely parallel those of MCC/HFP. In fact, all children who receive free or reduced price meals are very likely to be income eligible for MCC or HFP. Children with family incomes up to 130% of the federal poverty level (FPL) are considered eligible for free meals. Many of these children are very likely be income eligible for MCC. Children with family incomes between 131%-185% of the FPL are considered eligible for reduced price meals. These children are very likely to be income eligible for either MCC or HFP.

Approximately, 2.8 million children receive free or reduced priced meals in California on an average day through NSLP. At this time, it is unknown how many NSLP free and reduced price children are uninsured.

### Possibilities for Implementing the Options

### Option A: Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. Some school districts currently distribute information and applications for MCC/HFP along with the application for the NSLP. This practice could be expanded to include more schools.

In addition, the referral process could be enhanced if all schools were to distribute a standard MCC/HFP referral form with NSLP applications. Parents would complete this

form to obtain a MCC/HFP application and return it to the school, which would then forward it to MCC and HFP. CDE recommends this approach of using a separate form, rather than revising the NSLP application to obtain parental consent to release information already provided on the application.<sup>50</sup>

Under Federal law, NSLP applications may be used to provide family contact information to MCC/HFP as part of the referral process so that MCC/HFP could followup to complete enrollment. The Federal Agriculture Risk Protection Act (P. L. 106-224) and subsequent regulations from USDA address the sharing of eligibility information between federal nutrition programs such as NSLP and other federal and state programs, including health insurance programs. The regulations allow the eligibility status for nutrition programs to be shared with health programs without parental consent.<sup>51</sup> 42 U.S.C. 1758(b)(2)(C)(iii)(IV) now provides that information from an application for a free or reduced price meal or from the "school food authority" can be disclosed to "a person directly connected with the administration of the State Medicaid program ... or the State children's health insurance program ... solely for the purpose of identifying children eligible for benefits under, and enrolling children in, such programs." That section further provides that it applies "only to the extent that the State and the school food authority so elect." However, the sharing of the detail regarding nutrition programs eligibility (i.e., income, family size, SSN) with health programs would require parental consent.

Notwithstanding these federal guidelines, CDE indicates that the California Education Code restricts the sharing of *any* NSLP information. The Education Code Section (ECS) 49557 states that lists of children eligible for free and reduced price meals "shall not be...used for any other purpose than the National School Lunch Program." ECS 49558 reiterates that applications and records shall be confidential and "shall not be open to examination for any purpose not directly connected with the administration of any free or reduced price meal program."

It is unclear whether, notwithstanding Sections 49557 and 49558, other Education Code provisions would permit the sharing of certain information from NSLP applications with parental consent. CDE has not provided clarification on this issue, but instead maintains the position that the confidentiality provisions in these sections are essential to ensure applicants' trust and maintain children's access to NSLP meals. CDE also indicates that other sections of the Education Code that permit the sharing of pupil records with parental consent are not applicable to NSLP information. <sup>52</sup>

grant permission for schools to forward their contact information to MCC/HFP.

<sup>&</sup>lt;sup>50</sup> The option of revising the NSLP application to obtain parental consent is not possible when schools use direct certification or an alternative daiming mechanism for NSLP. Instead, these schools could send a separate consent form home with children participating in NSLP so that, at a minimum, families could

This approach is being used in New York City, and is described at the end of the program profile. Education Code Section 49075 provides that "a school district may permit access to pupil records to any person for whom a parent of the pupil has executed written consent specifying the records to be released and identifying the party or dass of parties to whom the records may be released." CDE interprets the definition of "pupil record" as defined in Education Code Section 49061 (b) narrowly. Thus, CDE maintains that Education Code Section 49075, which permits the release of information from pupil records, does not apply to the release of contact or eligibility information from a NSLP application.

CDE is working with NSLP sponsors to identify strategies to promote awareness of MCC/HFP and increase enrollments. A successful method used by NSLP sponsors is to attach MCC/HFP promotional materials and contact information to the NSLP application. NSLP sponsors are opposed to adding any type of parental release language for the MCC/HFP, either on or attached to the NSLP application, for several reasons.

First, MCC/HFP requires documentation of U.S. legal immigration status, and HFP requires documentation of citizenship. This documentation is not required to obtain meals under the provisions of the NSLP. NSLP sponsors provide outreach and encouragement for all children eligible to participate in the program and feel that an additional requirement to add a MCC/HFP parental release option, or "check off" box on the NSLP application requesting information about MCC/HFP, would deter some applicants from applying for either NSLP or MCC/HFP.

Another sponsor concern is potential liability related to assurances of confidentiality, if the applicant does not understand the consequences associated with selection of the option releasing information to MCC/HFP. Sponsors do support providing information about the program, but ask that this information be provided as a separate document. This document would be distributed simultaneously with the NSLP applications during other promotional opportunities.

In addition, if SSNs and other eligibility information from the NSLP application are shared with persons making MCC/HFP eligibility determinations, modifications would be necessary to the privacy disclosure information on the NSLP application, which poses an additional concern.

Another major concern for NSLP sponsors is the increase in workload. If parental consent for sharing enrollment information with MCC/HFP is required as part of the NSLP application, there would be added staff requirements, including: establishing required procedures; answering questions; and making appropriate referrals.

In response to these concerns, rather than appending any type of request for parental release of information, CDE recommends the use of a separate MCC/HFP referral form attached to the NSLP application. This approach has produced excellent results in a variety of pilot programs. CDE is willing to work with DHS and MRMIB to develop such a standard referral form.

Support among NSLP stakeholders of an enhanced referral process appears likely since the California School Food Service Association supported Assembly Bill 1735 (Thomson), introduced in September 2000, which would have required that "in making available to pupils the application for participation in the free or reduced-price meal program ... each school district and county superintendent of schools shall also include a request form that parents may use to request information concerning the Medi-Cal program..."

Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is not feasible for NSLP. It is not practical for school foodservice directors affiliated with NSLP to provide education or on-site application assistance for MCC/HFP, since these individuals do not have daily contact with recipient families. This would be an entirely new function for them that would be difficult to incorporate into existing workloads. However, it is promising for schools to provide this assistance through non-school personnel such as out-stationed EWs, public health nurses and local CAAs who are located at the school site. Another option would be to have school personnel such as school nurses and school health coordinators conduct these activities; however, many schools do not currently have school nurses or health coordinators.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP, and other programs

This option is not feasible. NSLP application formats vary among districts and even among schools within the same district, and schools may use direct certification or an alternative claiming mechanism for NSLP. For these reasons, a common application could not be developed at the State level and mandated for local use.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

The federal income guidelines for free and reduced price meals through NSLP closely parallel those of MCC/HFP. In fact, all children who receive free or reduced price meals are very likely to be income eligible for MCC or HFP. Children with family incomes up to 130% of the federal poverty level (FPL) are eligible for free meals. Many of these children are very likely be income eligible for MCC. Children with family incomes between 131%-185% FPL are eligible for reduced price meals. These children are very likely to be income eligible for either MCC or HFP.

There are differences between NSLP and MCC/HFP, however, that would require MCC/HFP to follow up with families for additional information and recalibrate information were it to be provided by NSLP. First, NSLP does not require documentation of income whereas MCC/HFP does. Second, NSLP exempts only one type of income when establishing family income level, while MCC/HFP exempts approximately 23 types of income. Finally, household composition is determined very differently in NSLP than in MCC/HFP (e.g. NSLP counts all adults and all children in the household, while MCC/HFP looks at family relationships and may not count all adults and children living together as one household).

As discussed under Option A, the sharing of NSLP contact and income eligibility information is permitted under federal regulations pertaining to the implementation of the Agriculture Risk Protection Act (PL 106-224) enacted in June 2000. Federal regulations now permit the eligibility *status* for nutrition programs to be shared with health programs without parental consent. However, this federal guidance does not authorize the sharing detailed eligibility information (i.e., income, family size, SSN) with health programs without parental consent.

As also discussed under Option A, more restrictive state statutes, California Education Code Sections 49557 and 49558, restrict the sharing of contact and eligibility information with other programs, although it is not clear whether certain information could, in fact, be shared with parental consent. It is CDE's position, however, that the confidentiality provisions in these sections are essential and supported by NSLP sponsors and participants. There are no citizenship or immigration requirements for NSLP. To share eligibility information with other programs that do have such requirements might deter families from applying for meal benefits. NSLP stakeholder groups share this position.

Due to school foodservice workload concems, the restrictions on releasing eligibility information, and the need to maintain applicant confidentiality and trust in the NSLP, CDE is opposed to any revision of the NSLP application that would request parental consent to release any information, including contact and eligibility information to MCC/HFP.

### Option E: Grant presumptive eligibility for MCC and/or HFP

Federal law allows schools to be qualified entities for the purpose of determining presumptive eligibility. Schools could grant presumptive eligibility to children based upon the income information provided on the NSLP application. The presumptive eligibility determination could be made by school personnel (i.e., school nurses and health coordinators) or out-stationed county staff (i.e., EWs and public health nurses). It is not feasible for school foodservice directors to make this determination because their regular job duties would not allow for the additional responsibility, even if they were sufficiently familiar with MCC and HFP.

#### Lessons Learned From Other States and Counties in CA

**Washington State** is making efforts to strengthen coordination and sharing of information between its Medicaid and NSLP. They will soon pilot a new NSLP application featuring an "opt-out" box for parents to check if they *do not* want contact and eligibility information shared with Medicaid. Unless a parent checks this box, information will be automatically forwarded to Medicaid for follow-up and enrollment. The pilot will also attempt to cross-match NSLP data files with Medicaid eligibility files to identify children who are already enrolled in Medicaid.

**New York City** is piloting an innovative, school-based approach to getting children enrolled in health coverage programs. The city's Board of Education, Department of Social Services, and Health Department are working together in this effort, which targets children receiving free and reduced price lunches. New York City estimates that 300,000 of these children may be uninsured and potentially eligible to Medicaid or the Child Health Plus state SCHIP program.

New York City's Board of Education sends a list of names of the students receiving free and reduced price lunches to the Health Department. A Health Department employee then contacts each child's parents and inquires about the child's health insurance status. If the child is uninsured, then the worker explores eligibility for Medicaid, and if

eligible, the child is enrolled. If the child is not eligible for Medicaid, then the worker pursues enrollment in Child Health Plus.

While there is no cost to the school to participate in this effort, there are financial incentives to get children enrolled. Each school that successfully enrolls a specified percentage of its eligible children receives a no-strings-attached bonus. The bonus is \$25,000 for schools enrolling 70% of their eligible children, and \$50,000 for schools that enroll 100% of their eligible children. These bonuses encourage the schools to participate in this outreach. The New York City Health Department provides funding for the bonuses, training, and staff. Over 70 full-time New York City staff has been hired to contact parents and facilitate health-coverage-plan enrollment, and hiring is expected to continue, up to 150 staff. New York City further brings to the schools health plans and community-based organizations to get uninsured children enrolled in Medicaid or Child Health Plus. Ninety-six community-based organizations, which receive \$50 per successfully enrolled child, are now working with health plans to reach children and get them enrolled. New York City indicates that a key part of their program is the use of their health workers to coordinate the outreach with the schools, community-based organizations, and health plans.

#### Snapshot of Options

Α

### School Health Connections (SHC) and School-based Efforts

### **Program Description**

Schools are an important site for MCC/HFP outreach and education. Many school districts and schools throughout California are implementing innovative outreach and education strategies. DHS' School Health Connections (SHC) Office has taken a lead role at the State-level in the promotion, outreach and technical assistance for MCC/HFP and other affordable health care options targeted toward schools.

SHC is an interdepartmental program between DHS and CDE dedicated toward improving the health and academic achievement of children and youth. SHC's goal is to develop a statewide infrastructure that supports a coordinated school health system. SHC takes advantage of the pivotal position of schools in reaching children and families by combining health education, health promotion, disease prevention, and access to health-related services in an integrated manner.

In January 1999, SHC received funding from the David and Lucile Packard Foundation to implement a MCC/HFP School Outreach Plan. The School Outreach Plan is designed to identify and enlist key education-affiliated organizations throughout California in promoting affordable health care for children to their membership and boosting enrollment in MCC/HFP. Implementation goals include:

- Providing technical assistance to state- and local-level partners on MCC/HFP outreach efforts targeted to schools;
- Maintaining/expanding partnerships with state-level, school-affiliated associations to promote local efforts and the adoption or establishment of a school board policy related to MCC/HFP outreach and enrollment; and
- Disseminating best practices through various communication and marketing strategies to opinion leaders.

SHC facilitated outreach mainly through three efforts to achieve these goals. These efforts focused on the National School Lunch Program, School Superintendents, and School Board Policy:

• National School Lunch Program: A direct mailing was sent in April 1999 to all school district food service directors in California urging them to inform parents about MCC/HFP by sending out Parent Request for Information flyers with the Free and Reduced Price Meals applications. For schools that sent flyers to parents, interested parents completed the flyer and returned it to the school. The school then forwarded the flyers to DHS who then mailed parents information and applications. Over 140 school districts from 48 counties participated in this effort during the 99/00 school year. CDE distributed a similar mailing in April 2000. Partners in this effort include: CDE, Consumers Union, DHS' Medi-Cal Eligibility Branch, and MR MIB.

- School Superintendents: A direct mailing was sent in June 1999 to all county and district superintendents, school nurses, and Healthy Start coordinators. The letter requested that schools send home an endosed MCC/HFP enrollment information flyer to parents in back-to-school packets, at back-to-school nights, with school lunch menus, and a variety of other venues throughout the year. Approximately 130 school districts from 40 counties participated in this effort. A similar mailing was sent out by DHS in June 2000. Partners in this effort include: CDE, DHS' Medi-Cal Eligibility Branch and MRMIB.
- School Board Policy: SHC worked in conjunction with the California School Boards Association (CSBA) and CDE to create a sample school board policy that relates to student health and its link to a child's ability to learn. Participation in MCC/HFP outreach and enrollment efforts is an integral part of the policy. The sample policy has been distributed to all CSBA members. In general, CSBA's sample policies serve as a key mechanism to forming policy in many of the state's 1,000 school districts. SHC will target 50 districts throughout the State urging them to adopt the policy. Districts selected lie within counties with a high percentage of uninsured children and which have a high percentage of children eligible for free or reduced price meals. Schools will be linked to their local health department and/or with MCC/HFP contractors or enrollment entities that can assist the district in outreach and enrollment efforts.

Outreach through School Superintendents and the NSLP have resulted in the State receiving over 50,000 requests from families for MCC/HFP information and applications (fiscal year ending June 2000). During the 1999-00 school year, approximately 27% (270) of California's school districts participated in MCC/HFP outreach as a result of efforts through the NSLP and superintendents. Data from the current fiscal year show that schools continue to be one of the top referral sources for MCC/HF information and applications.

### Uninsured Children Potentially Reached Through Schools

Over 5.8 million children attend public schools at approximately 8,000 school sites. At this time, it is unknown how many of these children are uninsured. MCC/HFP outreach and education could be targeted to those school districts that lie within counties with a high percentage of the State's uninsured and with a high participation in NSLP.

#### Possibilities for Implementing the Options Through Schools

### Option A. Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. The referral model is currently operating very successfully in some schools and school districts with the assistance of SHC and its partners. An allocation of \$6 million for HFP/MCC school outreach has been included in the Governor's Budget for FY 2001-2002, subject to approval of the Legislature. This allocation would provide funds to school districts and schools to conduct more extensive outreach efforts. Districts currently function on limited resources. Funding would allow districts to hire staff that can coordinate MCC/HFP outreach within the district, including

follow-up efforts with families. Hiring district staff also helps overcome confidentiality issues.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. The on-site assistance model is being implemented in some schools currently and could be expanded to more schools with assistance from SHC and funding for schools.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

It is not feasible to implement this option through schools.

## Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

Income and other eligibility information collected by on-site school nurses, public health nurses or health coordinators could be shared with MCC/HFP to initiate the MCC/HFP application process. However, few schools have school nurses or health coordinators. Schools with on-site programs such as Healthy Start or Head Start could share this information with MCC/HFP to the extent that it is collected. Please see the program summaries for Healthy Start and Head Start for additional information on options for streamlining enrollment into MCC/HFP in coordination with Healthy Start and Head Start.

For the reasons discussed in the profile for NSLP, sharing eligibility information from the NSLP with MCC/HFP is not a preferred option by CDE at this time.

### Option E: Grant presumptive eligibility for MCC and/or HFP

Schools are qualified entities for granting presumptive eligibility under federal law. Sites with school nurses, school-based clinics and other school-based programs such as Healthy Start and Head Start could grant presumptive eligibility to children to the extent that family income information is collected.

Connecticut is currently piloting presumptive eligibility for Medicaid in five school-based clinics. School nurses who identify an uninsured child obtain income information from the child's family and fax it to the state Medicaid office for processing. The state office grants presumptive eligibility based upon this information, and completes a final eligibility determination during the forty-five day presumptive eligibility period after contacting the family for additional information.

#### Lessons Learned from Other States and Counties in California

The Alum Rock Union Elementary School District in eastern San Jose serves 16,000 students and has an estimated 10,000 children with no form of health care coverage. The district holds Application Assistance Days designed to bring parents from throughout the county together at school sites for help in filling out affordable health care coverage application forms. Over the past school year, Alum Rock assisted parents in enrolling over 1,487 children in affordable health care coverage. Alum Rock is also one of the first districts in California to adopt a school board policy supporting outreach efforts for affordable health care coverage.

Health Access, an organization based in the Bay Area, is conducting MCC/HFP outreach in coordination with the **San Francisco Unified School District**. The approach is to distribute a standard Request for Information (RFI) form to all students in the schools. Parents who desire further information about MCC and HFP return these forms in pre-paid postage envelopes, which are forwarded to the appropriate agencies at the local level for follow-up with families.

A similar effort is underway in San Joaquin County. The San Joaquin County Health Care Services Agency is working with the **Stockton Unified and Manteca Unified School Districts** to mail and distribute MCC/HFP flyers at schools. Included with the flyers are postage-paid envelopes that are sent to Health Care Services Agency for direct follow-up with families.

**Pittsburgh Unified School District** distributes a flyer, on district letter, at the beginning of the school year. Return of the flyer is mandatory for all students. Parents are asked to identify if they want more information on HFP/MCC. If they indicate "yes," the form is sent to their health department, which conducts direct follow-up with families.

Pasadena Unified School District conducts enrollment outreach in partnership with the Children's Health Access Task Force, which is comprised of 35 community-based organizations including the health department. "School Jam," a central part of their efforts, involves an intensive outreach in each of the district's 30 schools, in one school per week. Priority for school outreach is based on the percentage of students in each school who are eligible for free/reduced price meals through NSLP. Parents receive letters about MCC/HFP, and each student receives a ruler with the logo and outreach number. Parents are targeted through different activities such as after-school programs, English as Second Language parent classes, and PTA meetings. The health department stresses that the activities and approaches are targeted to the needs of each school. An effort is made to target all of the places where parents can be found. There is also a strong emphasis on follow-up.

A group of students at **Richmond High School in West Contra Costa County** are taking the lead in encouraging uninsured young people to enroll in health care coverage. Teens provide information through class room presentations to their peers, at community health fairs, church events and back-to-school events. Not only are these young people improving their presentation skills and developing confidence levels, but they are successfully presenting the case to their classmates that teens need to be active in their own health needs. The teen project is part of an overall coordinated

outreach effort overseen by Communities in Schools. During the past school year, Communities in Schools have assisted parents in enrolling over 1,025 children in affordable health care coverage.

A massive health care coverage outreach movement in **San Diego County**, targeting uninsured children, is building partnerships and relationships throughout the county to find ways to provide health insurance. The San Diego Kids Health Assurance Network (SD-KHAN) proves that collaboration is a powerful tool as over 60 partners throughout the county, representing local community-based organizations, hospitals, government agencies, health plans, faith entities, businesses and school districts have joined together to get affordable health insurance to uninsured children. The San Diego Unified School District (SDUSD) and the Health-insurance Access Through Schools (HATS) program are active partners. In January of 1999, SDUSD's superintendent Alan Bersin set a goal of enrolling a thousand children a month in Healthy Families, Medi-Cal and other affordable health care coverage programs. Enrollment in SDUSD is 22,438 as of August 2000. Helping to make that number a reality was HealthLink, a program operating in the district that actually sends enrollment workers onto school sites to enroll parents. HATS also conducts outreach to enroll eligible children in health care coverage programs. HATS runs in five San Diego County school districts and has served 42 school sites to date.

Recognizing that no one knows parents better than they know each other, **Los Angeles Unified School District** (LAUSD), with the highest rate of uninsured children in the nation, is employing parents to help bring affordable insurance to children. Parents present information on Healthy Families and Medi-Cal for Children at parent gatherings in their school areas. Affordable insurance enrollment numbers grow through the district program, while at the same time, parents are gaining business and presentation skills that will allow them to continue working in the business market. LAUSD also conducts enrollment events with the help of community partners. One recent enrollment event yielded approximately 500 applications for affordable health care. LAUSD has assisted parents in enrolling approximately 2,200 children in affordable health care coverage from January through October 2000. Through school-linked referrals, approximately 2,000 additional children were reached.

### Snapshot of Options

A, B, D, E

### California's Healthy Start program

### **Program Description**

Administered by CDE, the state-funded Healthy Start Initiative provides grants for schools in coordination with local communities to provide school-linked services. Schools may apply for \$400,000 Operational Grants, which span 3-5 years, or \$50,000 Planning Grants, which span 2 years. The grants are competitive and the operational grant is one-time only. The school and local community collaborative are funded for services and activities to meet the needs of the students and their families as identified by a community needs assessment. Services to children and their families through Healthy Start could include counseling, after school programs, parent information, linkages with county social and health services, or any activity which helps students achieve success in their lives through the academic setting.

After the last funding year, the district agrees to continue the services through the collaborative member agencies and other sources. The Healthy Start Initiative distributed \$39 million in 1999-2000. Following guidance in the enabling legislation (SB 620, 1990), Healthy Start issues a Request for Applications every year on November 1 to elementary, middle, and high school districts throughout California. Low income schools, or schools with at least half of their students eligible for free or reduced price meals, may apply for a grant. Additionally, 10% of Healthy Start monies are reserved for schools who don't meet the low-income criteria, but who can demonstrate that funds are needed to respond to the unique needs of their students and community. Any child, regardless of family income, who attends a school with a Healthy Start operational grant, may receive services.

### Current Linkages to MCC/HFP

The CDE Healthy Start office encourages all Healthy Start grantees to provide information and assistance in applying for MCC/HFP. Healthy Start grantees receive information about MCC/HFP from the DHS School Health Connections Office. In addition, many Healthy Start staff are trained as CAAs.

### Uninsured Children Potentially Reached Through the Program

In 1999-2000, approximately 257 schools received Healthy Start grants. Over the ten years, 1,800 schools have received Healthy Start grants. However, not all students receive services through Healthy Start. Healthy Start collects specific information on a small number of students for evaluation purposes, but does not consistently collect health insurance information or family income information. Thus, it is unknown how many uninsured children could be reached through activities of Healthy Start grantees.

### Possibilities for Implementing the Options

### Option A: Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option and has worked well in most schools with Healthy Start grants. Healthy Start grants are given to a local collaborative of community agencies. Each collaborative member has a memorandum of agreement to provide services and staff at the school site. School staff have interagency agreements and meet as teams to discuss issues, so they are aware of the referral process. Healthy Start staff usually follow-up and can advocate for the family with MCC/HFP as well as other programs. One way to enhance the referral process with Healthy Start would be for all sites to use a standard referral form and forward those on behalf of parents to MCC/HFP.

## Option B: Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This is a promising option and has worked well with some Healthy Start grantees. Many Healthy Start staff are certified as CAAs. In addition, Family Resource Centers or Parent Centers affiliated with Healthy Start grantees are in schools where staff help families with MCC/HFP enrollment as part of their services. However, the extent and quality of this assistance could be enhanced with other sources of funding since funds granted to Healthy Start grantees are already committed to activities written in their proposals.

# Option C: Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not feasible since most Healthy Start staff provide services for the general population of the school and use individual applications for specific services such as referrals for counseling. Each grantee responds to the unique needs of the school and community and designs its own application forms for use when needed.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option may be feasible for some Healthy Start sites to implement on a limited basis. Staff of Healthy Start programs and collaborating schools and local agencies may not specifically ask or know about the family income of children they serve. In some cases, program staff will have this information; however, it is not likely that they would share the information without parental consent. It is not possible to design a standard Healthy Start application form with a standard consent release since each program offers different services and uses different application forms. However, one option is for the CDE Healthy Start Office to collaborate with MCC/HFP to design a stand-alone consent form to release information form that could be used by each site in addition to its own forms. Once parental consent is obtained, the Healthy Start site would use the standard consent form to send the family's income information to MCC/HFP by mail or fax.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This option may be feasible for some Healthy Start sites to implement on a limited basis since schools may be designated as qualified entities for granting presumptive eligibility, according to Federal law. Staff of Healthy Start programs and collaborating schools and local agencies may not specifically ask or know about the family income of children they serve. In some cases, program staff will have this information and it could be used to grant presumptive eligibility. If a Healthy Start site does grant presumptive eligibility for MCC/HFP, the program staff could ask about the family income for any families that are interested in receiving presumptive eligibility for their children.

### **Snapshot of Options**

A, B, D (limited), E (limited)

### Child Care Food Program (CCFP)

### **Program Description**

The Child Care Food Program (CCFP) provides supplemental reimbursement to eligible child care centers and day care homes so that better quality food may be served to the enrolled children. CDE administers the program and has agreements or contracts with nearly 850 public and private agencies that sponsor over 30,000 centers and homes. Local agencies determine children's eligibility for the program. The program's primary age group is 0 to 12 years. Migrant children, however, may be served until the age of 15 years, while children with special needs or disabilities essentially have no age limit. Within the After-School At-Risk portion of the CCFP, children up to the age of 18 years may be served.

The basis for reimbursing child care centers differs from that used for day care homes. Centers receive reimbursement based upon the free, reduced price, and paid eligibility of the enrolled children. Eligibility is determined through an application process. Applicants must provide their gross wages or salaries, with the exception of self-employed persons who may provide net income. Documentation is not required. Adjustments to income generally are not allowed. Children who are eligible for Food Stamps, CalWORKS, Food Distribution Program on Indian Reservations, Head Start, or Even Start are categorically or automatically eligible for free meal reimbursement. Children may also be eligible based on family size and income guidelines issued by USDA. Children at or below 130 percent of FPL are eligible for the free rate. Children between 130 and 185 percent are eligible for the reduced price rate. Children above the 185 percent level qualify for the paid rate.

Day care home providers, on the other hand, are paid according to a two-tier system of reimbursement (high and low), which may or may not involve an eligibility application process. Thus, a provider may qualify for the higher reimbursement because of location within a needy area (school or census data with a minimum threshold of 50% needy); and as a result, no eligibility information is taken. If the provider does not reside in a needy area, the eligibility process then may be employed, either for the provider or the children in care, in which case, either a free or reduced price eligibility status will qualify the provider or the children for the higher reimbursement.

Local CCFP agencies maintain eligibility information, and this information is not submitted to CDE. Local agencies do submit monthly reimbursement claims to CDE on behalf of their sponsored centers or homes. CDE disburses the reimbursement to the agencies. In the case of day care homes, the sponsors, in turn, disburse the payments to the providers.

### Current Linkages to MCC/HFP

At this point, the CCFP program does not conduct extensive MCC/HFP outreach and education. Some local CCFP agencies may do some MCC/HFP outreach and assistance though the vast majority of the agencies do not.

### Uninsured Children Potentially Reached Through the Program

More than 430,000 children participated in the CCFP during the 1998-99 Program Year. Of these, about 83 percent qualified for the free rate (below 130 percent of FPL) and 5 percent qualified for the reduced rate (between 130 and 185 percent of FPL). All of these children are very likely to be income eligible for MCC or HFP.

### Possibilities for Implementing the Options

### Option A. Establish or enhance referral processes between other programs and MCC/HFP

CDE supports the establishment of a referral process with MCC/HFP. Local CCFP agencies could dispense basic MCC/HFP information. Large and moderate-sized child care agencies could receive the necessary training and materials to provide MCC/HFP referrals to those families whose children are served by CCFP. The referral efforts of such agencies should be part of a systematic approach that will provide better service and avoid duplication of effort.

Under Federal law, CCFP agencies could provide family contact information to MCC/HFP as part of the referral process so that MCC/HFP could follow up to complete enrollment. The Federal Agriculture Risk Protection Act (P. L. 106-224) and subsequent regulations from USDA address the sharing of eligibility information between federal nutrition programs such as CCFP and other federal and state programs, including health insurance programs. The regulations allow the *eligibility status* for nutrition programs to be shared with health programs without parental consent. However, the sharing of *the detail regarding nutrition programs eligibility* (i.e., income, family size, SSN) with health programs would require parental consent.

CCFP shares similar concerns as the NSLP in regard to releasing contact information to MCC/HFP through the CCFP application. These concerns include the need to maintain applicant confidentiality and the feasibility of obtaining parental consent. For these reasons, CDE opposes revising the CCFP application to give families an opportunity to grant consent to the sharing of this information. However, CDE would be willing to work with MCC/HFP to develop a standard referral form that families could complete to provide their contact information. Families would return these forms to CCFP, which would forward them to MCC/HFP.

## Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is possible. Local CCFP agencies could receive the appropriate education, training and materials to provide education and on-site application assistance for MCC/HFP. Only certain child care agencies are likely to be willing and able to provide training and on-site assistance. Clearly, an agency's service area must have a demonstrated need for the agency to undertake this role. The on-site assistance function must be comprehensive and coordinated so that the agency is part of an organized effort to provide this assistance within a given area. On-site application

assistance could also be provided through collaborative efforts between CAAs, outstationed EWs and CCFP agencies.

# Option C: Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

A common application (whether paper or automated) is not feasible. The CCFP regulations prescribe the content of the application, with a particular emphasis on a statement of confidentiality. The same regulations state that the family size and income information given for the determination of free or reduced price meal eligibility must be kept confidential.

# Option D: Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

All children receiving free or reduced price food are very likely income eligible for either MCC or HFP. However, there are differences between CCFP and MCC/HFP that would require MCC/HFP to recalibrate information provided by CCFP. One challenge is that while CCFP uses gross income when determining family income level, MCC/HFP uses net income after applying income deductions.

As discussed under Option A, under Federal law, CCFP agencies could provide eligibility information to MCC/HFP with parental consent. However, CDE opposes the sharing of eligibility information, even with parental consent, for two reasons. First, CDE indicates that the confidentiality of the eligibility information may be breached. Confidentiality is essential to the success of all child nutrition programs. Furthermore, child care agencies may be unnecessarily exposed to the risk of certain legal actions against them.

Second, citizenship is not required for participation in CCFP, whereas it is a requirement for MCC/HFP. Parents may perceive that the sharing of eligibility information may expose their citizenship status to immigration authorities. Consequently, concerned parents may remove their children from the CCFP if they believe that CCFP participation would lead to further inquiries about their immigration status. This would hamper children's access to nutritious meals.

### Option E: Grant presumptive eligibility for MCC and/or HFP

CDE indicates that this is not a feasible option due to its concerns about sharing eligibility information with MCC/HFP. Furthermore, CDE believes that few, if any child care agencies would be willing to undertake this role.

### Snapshot of Options

A, B

### Child Care and State Preschool Programs

### Program Description

Programs funded by CDE through the Child Development Division (CDD) provide full and part-time comprehensive and developmentally appropriate early education and child development services to children birth to age 14 and their parents, both full and part-time. Services are subsidized and provided primarily, but not exclusively, to low-income families, largely through the State Preschool (SPS), Alternative Payment (AP), and Center Based (CB) programs such as General Child Care.

CDE contracts with 859 agencies statewide to serve families eligible for early education and child development services. Children whose family income does not exceed 75% of the state median income (SMI) are eligible for AP and CB subsidized child care services (75% of the SMI is roughly equivalent to 229% of FPL). Children aged 3-5, whose family income does not exceed approximately 60% of SMI depending on family size, are eligible to attend SPS (60% SMI is roughly equivalent to 221% FPL). Parents apply in person at contracting agency headquarters or satellite offices/centers. Applicants must provide documentation of, or self-declaration for, all reported income. CDE programs consider gross, not net, income for eligibility purposes. Immigration status is not an eligibility requirement.

Due to a funding cap, these programs cannot serve all eligible children. In all cases, Child Protective Services (CPS) referrals get first priority. Families are then ranked by income, with lowest per capita income families having a higher priority for services than higher income families. CB and AP program applicants must also have a qualifying need for child care services, such as work, job training, seeking employment, incapacity, homelessness, or a CPS referral. CB and AP families may also pay family fees, depending upon their incomes. For SPS, priority is given to 4-year-olds (lowest per capita income first), then 3-year-olds (lowest per capita income first).

Child development agencies may create their own application forms, although many use one designed by CDE. Applications are maintained locally and not sent to CDE in either print or electronic form.

CDE has very limited data on families receiving subsidized services. Names of heads of households and Social Security Numbers (SSN) for heads of households who consent to provide the SSN are stored on a departmental server. In addition, CDE receives information on whether a participating family is receiving TANF and if the family's income is greater, at or below 75 percent of SMI. Only CDE staff has access to this data. The data is maintained only for meeting state and federal reporting requirements.

### Current Linkages to MCC/HFP

Questions about a child's health insurance status are not routinely asked of families, but contracting agencies are required to ask questions about families' health and social services needs at application and during recertification, which occurs at least annually. Agencies are mandated to make referrals to appropriate health and social services so many families may be receiving referrals to MCC/HFP. Despite this requirement, many agencies do not routinely make referrals to MCC/HFP. Those agencies found out of compliance with this requirement are placed on corrective action plans.

### Uninsured Children Potentially Reached Through the Program

As of January 2000, over 75,000 children received CB services. Over 88,000 children are enrolled in SPS. Over 30,000 receive AP services. Since children may have family income up to 221% of FPL in the SPS program and 229% of FPL in the CB and AP programs, all children participating in these programs are very likely to be income eligible for either MCC or HFP. At this time, it is not known how many of these children lack health insurance.

#### Possibilities for Implementing the Options

### Option A: Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. CDE indicates that its Child Care and State Preschool programs are a natural place to identify children who are likely eligible for MCC/HFP and conduct outreach. These referrals are often already taking place, although the process is different with each local program, and in many cases, could be enhanced. Local programs know which children are receiving CalWORKs (and are therefore enrolled in Medi-Cal), and could screen out these children when making referrals to MCC/HFP.

MCC/HFP could supply Child Care and State Preschool programs with MCC/HFP applications and/or referral forms to give to families during the application process. Families could complete and submit these forms to the Child Care and Preschool programs, which would then forward them to MCC/HFP.

# Option B: Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option would have a workload impact on programs and be extremely difficult to implement without additional resources being made available to programs. One idea would be for a CAA or out-stationed EW to come to State Preschool sites during enrollment weeks (generally held in August or September of each year). The CAA could be available to assist parents in applying for MCC/HFP for their children. Another idea would be to have a CAA or out-stationed EW attend Child Care parent education meetings to speak to parents about health coverage enrollment.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not feasible due to the fact that child development agencies may create their own application forms and processes. Applications are maintained locally and not sent to CDE.

### Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

The income eligibility requirements for these child development programs are comparable to MCC/HFP. Since children may have family income up to 221% of the federal poverty level (FPL) in the SPS program and 229% of FPL in the CB and AP programs, all of these children are very likely to be income eligible for either MCC or HFP.

However, there are differences between these programs and MCC/HFP that would require MCC/HFP to recalibrate the information provided by the programs. First, Child Care and State Preschool do not exempt three types of income that MCC/HFP does. There are also substantial differences in how household composition is established. Another difference is that Child Care and State Preschool use gross income when determining family income level, while MCC/HFP uses net income after applying income deductions.

CDE program staff are not aware of any barriers to having parents sign a release of information form so that their income information can be shared with MCC/HFP. One possibility is for programs to revise their application forms to obtain parents' authorization to share the information with MCC/HFP. Alternatively, a stand-alone consent form could be developed in collaboration between CDE and MCC/HFP. CDE indicates that it would prefer the development of a separate form.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This option could potentially be implemented by those child care agencies receiving specified Federal funds (or by other child care agencies if desired by the State and approved by the Secretary of the U.S. Department of Health and Human Services). Federal law allows agencies that receive Child Care and Development Block Grant funds to be qualified entities for determining presumptive eligibility.

Child Care and State Preschool programs interview parents in person and child care sites have frequent, often daily, interaction with parents. However, presumptive eligibility would be very difficult for local programs to implement. Programs already have a very complicated eligibility determination process and might be unable to take on another process. If the presumptive eligibility process is very simple and easy to do, then local programs might be willing to undertake it. If the process is complex, it would be highly unlikely that local programs would elect to participate.

### Lessons Learned From Other States and Counties Within California

**Florida** is piloting a children's health coverage electronic application process targeted at Hispanic and Haitian children through day care centers. Incentives and application assistance fees will be offered to day care centers that assist families in completing electronic applications.

### Snapshot of Options

A, B, D, E

#### Federal Head Start Program

#### **Program Description**

Head Start is a federal child development program serving low-income children up to age 5 and their families since 1965. Head Start is charged with providing comprehensive services, including health care, nutrition services, and mental health services, to enrolled children. Head Start is administered directly by the federal government, under the U.S. Department of Health and Human Services, Administration on Children and Families (ACF), Head Start Bureau. Head Start programs in California are monitored by Region IX of the ACF, which is based in San Francisco.

There are approximately 150 local Head Start programs statewide. Every Head Start program is locally designed, has its own application, and may have selection criteria in addition to federal and state criteria. According to federal requirements, eligibility for Head Start is limited to children under age 5 with family incomes under 100% of FPL, or to children who are either in foster care, or are receiving SSI or are children of former CalWORKs participants. Ten percent of the children served may have family incomes exceeding the 100% FPL limit. Head Start uses a family's gross income in its eligibility determinations. Parents apply on behalf of their children in person at local Head Start sites and provide documentation of their income.

Each local Head Start utilizes a family data and tracking system known as the Program Information Report (PIR). This system may be paper-based or automated, but most programs use paper-based systems. PIR data is sent to a national data contractor for storage. Information may be shared with providers of medical services, federal, state and local agencies and EDS on a "need to know basis". To release other information or to release information to anyone else requires written consent from the participant.

#### Current Linkages to MCC/HFP

Head Start already connects most children to MCC/HFP. Each child enrolled in Head Start is required to have a "medical home," and each local program must ensure that all children have access to health care. Families complete a health questionnaire and those who are not already insured or receiving MCC or HFP are referred to those programs. Head Start files must document information about each child's health provider and insurance, so there is follow-up done on MCC/HFP referrals.

#### Uninsured Children Potentially Reached Through the Program

There are over 83,000 children under age 5 currently enrolled in Head Start in California. At least 90 percent of these children live in families with incomes under 100% of the federal poverty level (FPL) and would therefore, meet MCC income requirements. Ten percent of the children served may have family incomes exceeding the 100% FPL limit. Some children may be in the program by virtue of being in foster care, receiving SSI, or being children of former CalWORKs participants who are participating in a CalWORKs Work Plan. All of these children have categorical eligibility and are likely already receiving MCC.

Data on Head Start children is maintained at the local level. Local programs know which children are uninsured. For example, the Sacramento Employment and Training Agency (SETA) Head Start program serves 5,200 children; 20% of those children entered the program without health insurance.

#### Possibilities for Implementing the Options

# Option A: Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. The referral model is already operating successfully in many Head Start programs. Head Start programs connect children to MCC/HFP through referrals and by providing on-site assistance with applications. The process could be enhanced through use of a standard referral form and expanded to include additional Head Start sites.

# Option B: Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This is a promising option. The on-site assistance model is already operating successfully in many Head Start programs. Head Start programs connect children to MCC/HFP through referrals and by providing on-site assistance with applications. The process could be expanded to include additional Head Start sites.

# Option C: Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not seen as feasible due to the fact that application formats vary among local Head Start programs. Since Head Start is a federal program, a combination application could not be developed at the State level and mandated for use locally.

## Option D: Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This is a promising option. All of the children who are income eligible for Head Start are very likely to be income eligible for Medi-Cal (this does not include the 10% that don't meet Head Start income guidelines but are enrolled in Head Start). However, there are differences between the programs that would require MCC/HFP to re-examine the family's household and income information against MCC/HFP guidelines. One challenge is that while Head Start uses gross income when determining family income level, MCC/HFP uses net income after applying income deductions. Head Start also calculates household composition differently than MCC/HFP does, counting CalWORKs recipients and all children under 21 as household members while MCC/HFP does not.

There is no federal prohibition to releasing information with a parent's consent in the Head Start program. One option is for Head Start staff to seek a parent's written consent to forward a copy of the Head Start application to MCC/HFP when the program determines that a child lacks health insurance. This will probably require hard copy

transmission via mail or fax due to varying levels of automated data system capabilities at local Head Start programs. Due to the local-to-federal link, the State cannot mandate that Head Start programs do this, but can request and encourage their participation.

## Option E: Grant presumptive eligibility for MCC and/or HFP

This option is promising because all of the children who are income eligible for Head Start are very likely to be income eligible for Medi-Cal. Due to Head Start's commitment to ensuring that each child has a medical home, the Head Start staff contacted for the purposes of this report were enthusiastic about the potential to expedite MCC/HFP enrollment via presumptive eligibility.

### Lessons Learned from Local Programs

Many local Head Start programs go beyond simple referral and follow-up. For example, the **Sacramento Employment and Training Agency (SETA) Head Start** program meets with their Family Service Workers monthly to educate them about MCC/HFP, provides telephone follow-up to families with specific medical needs to ensure that they've enrolled, and matches families with CAAs for help with the enrollment process. A benefit of this process is that when Head Start works with a family to help them enroll in a health coverage program, all of the children in the family would be enrolled, not just the child attending Head Start. SETA Head Start just hired a Health Nutrition Specialist who may be trained as a CAA to assist Head Start families. Also under consideration is having one Head Start employee in each of the four Sacramento area Head Start site clusters whose primary role would be to help families enroll in MCC/HFP.

#### Snapshot of Options

A, B, D, E

#### Child Support Program

#### **Program Description**

The Child Support Program, authorized under Title IV-D of the Social Security Act, provides services to assist parents in their mutual obligation to financially support and provide health insurance for their children. The child support program is a cooperative federal/state/county effort to serve the public interest by establishing and enforcing court-ordered child support obligations. The program also will establish patemity when necessary.

The mission of the California Child Support Program is to promote the well being of children and the self-sufficiency of families by delivering first-rate child support services and collection activities that contribute to meeting the financial, medical and the emotional needs of children.

The program is operated by the local child support agency in each county under the direction of the State Department of Child Support Services (DCSS). The local child support agency performs the investigative, enforcement and legal work required to locate non-custodial parents, establish patemity, establish court orders for support (including medical support), and collect and distribute child support payments.

Child support payments are used to repay the government for public assistance paid to families, or are sent directly to the family if they are not receiving public assistance.

A case may be opened in one of three ways:

- Either parent may open a case by completing an application;
- The county welfare department will refer to the local child support agency any person who receives public assistance (including Medi-Cal) and a case will automatically be opened for them; or
- Another state may request child support enforcement.

The local child support agency collects income information, if available, from both parents to determine the appropriate child support award. In many cases, due to non-participation of the non-custodial parent in the process, income information is not available for the non-custodial parent and an order based on presumed income is set by default. The income for the non-custodial parent is documented when available. The income for the custodial parent is documented when available but may not be available in non-aided cases where an order is already established or on interstate cases unless procedures are changed to request this information.

Information is gathered on a case specific basis other than in the instance of paternity, which is tracked by each child. Counties collect and submit specified data to the state; but this does not include income information. Some counties may be able to do some ad hoc reports on individual level income data.

### Current Linkages to MCC/HFP

Almost every court child support order also includes an order for medical support. It is a requirement of the Child Support program to obtain health insurance for children if it is available at a reasonable cost. Securing health care coverage for families served by the Child Support program is a top priority for DCSS.

Until recently, it was believed that the federal government prohibited subsidized coverage through Medicaid or SCHIP from being sufficient to meet the requirement of the provision of medical support. However, a recent report from the Medical Support Working Group of the U.S. Department of Health and Human Services suggests that states should promote publicly funded coverage for IV-D children while private insurance is being pursued or is not available. In fact, guidelines for the child support programs in Connecticut and Texas specifically require the IV-D agencies in those states to seek enrollment for children in Medicaid or SCHIP if there is no other source of health insurance. Federal policy currently prohibits the use of IV-D funding for efforts to seek enrollment for children in Medicaid or SCHIP. However, the working group's recommendations may result in a change in this policy.

DCSS intends to interface with DHS and MRMIB to ensure the enrollment of children and their parents in MCC or HFP. The Balanced Budget Refinement Act gives states the option to allow local child support agencies to make presumptive eligibility determinations for Medi-Cal, and DCSS is analyzing the merits of this option. In addition, DCSS wants to develop in collaboration with MRMIB an affordable, unsubsidized health program for higher income level families.

#### Uninsured Children Potentially Reached Through the Program

The State has approximately 2 million child support cases. Child support orders exist in approximately 1.4 million of these cases. Medical support has been ordered in about 1 million cases.

Of the 1 million cases with medical support orders, private health insurance has been obtained in at least 20,000 cases, though it is likely that this number is an underestimate. In addition, it is likely that many of the children are already enrolled in Medi-Cal since approximately one third of the families receiving child support are also receiving CalWORKs, and thus assumed to be on Medi-Cal. It is not known how many of the remaining uninsured children with medical support orders have family incomes under 250% of FPL, and thus would be income eligible for either MCC or HFP, but it is presumed to be a substantial percentage. Some counties may be able to generate reports that identify the number of children in this income range who are very likely to be income eligible for MCC or HFP.

<sup>54</sup> "21 Million Children's Health: Our Shared Responsibility. The Medical Child Support Working Group's Report to Congress", U.S. Department of Health and Human Services, June 2000.

<sup>&</sup>lt;sup>53</sup> Establishing a medical support order would not be appropriate in cases in which only child support order arrears are due.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This option is promising and DCSS is actively pursuing involvement in the MCC/HFP education and outreach program. Outreach materials were mailed to each local child support agency when HFP began. Staff from HFP attended conferences to present information to local child support staff to encourage them to share the information with their clientele. Current county outreach and referral efforts vary. Current county efforts could be assisted or expanded by implementing the use of a standard MCC/HFP referral form for children after it has been determined that employer-provided coverage is not immediately available. Because IV-D funding cannot be used for MCC/HFP enrollment activities, additional funding may be required.

DCSS also intends to incorporate MCC/HFP outreach into DCSS' efforts in working with non-custodial parents in job-readiness programs and in their Hispanic Outreach demonstration programs.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. Because local child support agencies have income information for the custodial family and MCC/HFP eligibility is based upon the custodial parent's income, child support staff could be a good source of application assistance for MCC/HFP. In the future, it may be beneficial also to locate Health-e-App terminals in county Child Support offices. However, since federal policy currently prohibits the use of IV-D funding for efforts to seek enrollment for children in Medicaid or SCHIP, additional funding would be necessary to enable child support agencies to assist applicants in applying for MCC/HFP.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This option is not feasible. Due to the fact that a child support case may be opened because of a referral from the county welfare department or due to a request from another state, a common application is not seen as a good approach.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option is promising. Local child support agencies could develop reports on income of individual children. This data could be shared with MCC/HFP on families that appear to be income eligible. Although the IV-D program is authorized to exchange information with the Medicaid program, as a matter of policy, DCSS would want to ask the family if it is interested in applying to MCC or HFP and obtain permission to send the information to those programs. Using a standard consent form, a family's income information could be sent by mail or fax to MCC/HFP by the local child support agency.

## Option E: Grant presumptive eligibility for MCC/HFP

Federal law allows child support enforcement agencies to be qualified entities for granting presumptive eligibility and DCSS is reviewing the feasibility of this option. It is unclear if IV-D funds could be used for this activity or whether the State would fund these activities through the Medi-Cal program.

## **Snapshot of Options**

A, B, D, E

#### Alcohol and Other Drug (AOD) Programs

#### **Program Description**

The Califomia Department of Alcohol and Drug Programs (ADP) works to prevent and reduce alcohol and other drug (AOD) problems through public funding for local services provided by counties and community-based programs. ADP also licenses and regulates treatment and recovery programs and driving-under-the-influence programs. The Department works in partnership with county government to plan, develop, and implement a comprehensive statewide prevention, recovery, and treatment services delivery system. County alcohol and drug administrators function as the broker of local prevention and treatment services and contract with community-based substance abuse providers to meet local needs, priorities and requirements for service provision. ADP programs that are best suited to promote MCC/HFP enrollment include peri-natal programs and youth prevention and treatment programs.

There are approximately 250 peri-natal programs statewide, operating in 57 counties. Services in peri-natal programs are designed to empower women to achieve clean and sober living, deliver healthy infants, and strengthen family units. Annually, these programs serve over 12,000 pregnant and parenting women accompanied by approximately 18,400 children (from birth through age 17). Allowing women to bring their children with them into the program eliminates a major barrier to treatment for women and provides opportunities to improve mother-child interactions, to promote appropriate pediatric care (including child immunizations) and arrange for referral to therapeutic services. Women are referred to treatment programs in a variety of ways, including county child welfare services, the county public health department, their private physician, or self-referral.

The Youth Treatment Program was first funded in 1998 in twenty counties and has since expanded to include all 58 counties. The focus of the services varies depending on local need and priorities; however, youth treatment services are provided primarily at outpatient clinic sites in schools and communities. The levels of care and types of settings available include outreach, early intervention, low and high intensive outpatient services, residential treatment (in group home settings and juvenile detention facilities), and continuing care. Youth enter the substance abuse treatment system in a variety of ways, including referral from parents, health care providers, schools, and social services.

Youth prevention programming strategies include collaboration and coordination with Federal, State, and local agencies; promotion of alcohol and drug-free lifestyles through alternative activities; technical assistance and training for communities; and public information and education campaigns. Virtually all of the county AOD offices have relationships with local schools using their Friday Night Live (high school), Club Live (middle school) and Friday Night Live Kids (elementary) programs. Within youth prevention services, there may be opportunities for MCC/HFP materials to be made available to youth and families at these venues.

Neither ADP nor county AOD departments are "eligibility determining" entities and do not enroll individuals using a process like that used by MCC/HFP. Family income

information is not collected at the state level and there is no requirement that family income data be collected at the county level, though some counties may opt to do so. In addition, inquiries about health insurance are not a program requirement and may not happen routinely.

Some AOD treatment providers gather insurance information from persons seeking admission in order to bill third party payors, but this practice is not consistent. Many programs employ the Uniform Method of Determining Ability to Pay (UMDAP) for non-Medi-Cal patients, and some of these individuals may be charged based upon a sliding fee scale. However, no one is denied access to substance abuse services based on inability to pay.

## <u>Uninsured Children Reached Through the Program</u>

Along with the estimated 18,400 children that accompany their mothers into the perinatal programs, ADP's Friday Night Live prevention programs reach over 520,000 young people annually. It is unknown how many of these children and youth are uninsured. The California Alcohol and Drug Data System (CADDS) does not collect this information.

Because HFP is constructed like a commercial insurance plan, many members' identification cards do not identify them as HFP members, only as members of the health plan. Therefore, it is difficult for AOD treatment providers to identify a HFP member when they present for admission.

## Possibilities for Implementing the Options

# Option A. Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. This model could work in the peri-natal and youth treatment programs. Case managers in these programs could facilitate referrals to MCC/HFP for uninsured women, their children and youth by sharing information about the availability of MCC/HFP. Outreach materials and a standard referral form could be made available at prevention Friday Night Live activities/sites.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This is a promising option. This model could work in the peri-natal and youth treatment programs if programs become certified to provide application assistance to families.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not seen as feasible because ADP and county alcohol and other drug programs do not enroll individuals.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option may be feasible to implement on a limited basis only. AOD programs collect income information for some participants as part of the UMDAP process. To the extent that this information is collected, it could be shared with MCC/HFP with parental consent in order to begin the application process.

## Option E: Grant presumptive eligibility for MCC and/or HFP

This option is not seen as feasible since county alcohol and drug programs are not means-tested programs and do not usually collect income information. Most alcohol and drug programs would most likely not want to expand their role to do so, even if by granting presumptive eligibility they could enable the immediate use of services that could be billed to Medi-Cal.

## Snapshot of Options

A, B, D (limited)

#### **Mental Health Services**

#### **Program Description**

California has a decentralized mental health service delivery system with most direct services provided through the counties. At the state level, the Department of Mental Health (DMH) is responsible for administering federal funds, emphasizing accountability for performance outcomes, providing system leadership, program oversight and evaluation, and providing specified direct services including those rendered in state hospitals. At the county level, county mental health departments administer locally designed programs that are developed with input from mental health consumers and their families. County departments may provide services directly or may contract out for services. State DMH staff members provide technical assistance and consultation to counties to facilitate local development of systems of care and innovative programs. DMH does not enroll individuals and is generally not a point of contact for consumers, other than state hospital patients. However, DMH does offer ombudsman services to individuals enrolled in a county mental health managed care plan.

County mental health departments, or their contracted treatment providers, have direct contact with the consumers. Individuals enter the mental health system in a variety of ways, including referral from health care providers, schools, hospitals, parents, social service agencies, health plans, or self-referral. While all Californians may access mental health services, the priority population served includes children or youth with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Once a client is in treatment, the mental health provider attempts to determine that client's insurance status. Counties provide mental health services in accordance with the Medicaid State plan and are responsible for providing treatment services to all Medi-Cal clients who have a medical need for those services. Persons without Medi-Cal may receive services as well; no one is denied access to mental health services based on inability to pay. However, counties do refer individuals seeking mental health services to alternative care, if such care is available, as the public mental health system functions as a safety net provider.

If a person does not have Medi-Cal, Healthy Families, or private insurance coverage, the Uniform Method of Determining Ability to Pay (UMDAP) is used to determine what fee, if any, is charged, based upon a sliding fee scale. The UMDAP process includes the collection of family income information based on self-report. This data is maintained at the local level. The income is not verified.

#### Current Linkages to MCC/HFP

The frequency with which uninsured individuals are referred to apply for MCC or HFP varies among counties and providers. There is a financial incentive for counties to pursue MCC/HFP enrollment for their uninsured patients. Counties receive money from the sales tax, vehicle license fees (VLF), and the general fund to fund their mental health programs. Services for non-MCC/HFP-eligible consumers are funded from these sources (as well as federal block grant dollars), while services for MCC/HFP recipients are funded partially by the sales tax, VLF, and State General Fund (SGF), and partially

by federal financial participation (FFP). For example, if an SED child is enrolled in HFP, the counties receive approximately 65 percent of the cost of care from federal funds.

#### <u>Uninsured Children Potentially Reached Through the Program</u>

Data submitted by counties through December 12, 2000 indicate that more than 85,000 children ages 0-17 were served through county mental health services in FY 1999-2000. Preliminary data indicates that approximately 57,000 of these children are covered under the Medi-Cal program, while some 15,000 children have Healthy Families Program coverage. The remaining children may or may not be otherwise insured, but are not covered under these two public programs. It should be noted that the data for this time period is not yet complete, and these numbers may increase.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. DMH works closely with the California Mental Health Directors Association (CMHDA) and the California Institute for Mental Health (CIMH). CIMH has received funds from the Packard Foundation to support county mental health departments and participating health plans as they implement the mental health benefits of the HFP. One idea is to expand CIMH's role as a training arm for county mental health departments to increase referrals to health coverage programs.

Some county mental health departments are currently doing aggressive MCC/HFP outreach. Strategies employed by San Joaquin and San Francisco counties for HFP outreach, and those used by Stanislaus and Los Angeles counties for MCC outreach, may be applicable to other counties. Information about these efforts is at the end of this profile.

Use of a standard referral form may also be beneficial in helping county mental health departments to further promote and conduct referrals to MCC/HFP.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. Some county mental health departments already provide space and resources for county welfare department EWs to conduct Medi-Cal enrollment onsite. This could be expanded, and also could include HFP outreach and enrollment and assistance by CAAs.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not seen as feasible because DMH and county mental health offices do not enroll individuals in the same manner that MCC/HFP and other means tested programs do using an application.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option may be feasible to implement on a limited basis only. As part of the UMDAP process, individuals who have neither Medi-Cal nor private insurance coverage must provide income information to determine any applicable fee for services. This information is not documented or verified, and does not include information on assets. It is not clear whether and how counties maintain this information once it is collected. However, in some cases, it would be possible for county mental health departments to transmit this limited income information to MCC/HFP with the parent's consent in order to start the MCC/HFP application process.

#### Option E: Grant presumptive eligibility for MCC and/or HFP

This model would not be feasible to implement since most DMH contracted treatment providers do not collect any income information, and most likely would not want to expand their role to do so, even if by granting presumptive eligibility they could enable the immediate use of services that could be billed to Medi-Cal.

#### Lessons From Other States and Counties Within California

The **Stanislaus County Mental Health Department** has trained all of its clerical staff members to assist individuals in completing applications for Medi-Cal and to facilitate submission of these applications to the appropriate agency responsible for eligibility determination. The department has also developed a closer collaboration with the county welfare department in terms of co-locating eligibility determination with specialty mental health services either permanently, on a regularly scheduled basis, or as needed.

The San Joaquin County Mental Health Department was a partner in the countywide Healthy Families Coalition that was established in 1998 by the San Joaquin County Health Care Services Agency to develop strategies for client education and enrollment. The Coalition developed a cooperative enrollment strategy using the marketing expertise of the Health Plan of San Joaquin and the provider experience of the Health Care Services Agency. The strategy included development of enrollment sites at San Joaquin General Hospital, the Mental Health Department, Public Health Services, and the Office of Substance Abuse. Community-based sites such as WIC sites and school-based clinics were also included. More than 95 percent of enrollments that occurred in response to this strategy resulted from the Agency's partnership with the Council for the Spanish-Speaking (Concilio) team of outreach enrollers. The most effective marketing approach was conducting face-to-face visits with clients in their homes and neighborhoods. Other approaches included direct mail, clinic referrals. billboards, transit ads, brochures, an informational center at a shopping mall kiosk. By focusing on face-to-face marketing, the Agency was able to increase HFP enrollment applications by 32 percent within seven months of project start-up.

#### Snapshot of Options

A, B, D (limited)

#### **Developmental Services Regional Centers**

#### **Program Description**

The developmental services regional center system was established in the late 1960's by the Lanterman Developmental Disabilities Services Act. The Department of Developmental Services (DDS) contracts with 21 private, non-profit agencies called regional centers that fund a variety of services to individuals with developmental disabilities. Each regional center has its own board of directors to ensure responsiveness to local needs. Each regional center is responsible for serving individuals living in a specified geographic area, and tailors services and programs according to individual needs. Services range from genetic testing and counseling in high-risk pregnancies to service planning and coordination throughout an individual's entire life.

A developmental disability is defined in law as a disability that originates before the age of 18 years, can be expected to continue indefinitely, and constitutes a substantial disability for the individual. Qualifying conditions include mental retardation, cerebral palsy, epilepsy, autism, and many other syndromes and conditions. However, conditions are excluded which are solely physical in nature. Eligibility is based on clinical diagnosis, not income level. Income information is not collected. Once a person has been determined eligible by a regional center, he/she is generally eligible for the remainder of his/her life.

DDS also coordinates the Early Start program for California, a program that provides a one-stop shop approach to services for parents of children from birth to age 3 who are at risk of a developmental delay absent intervention. Regional centers assist families with high-risk infants and toddlers in applying for many generic resources and could systematically refer to MCC/HFP or other generic resources.

#### Current Linkages to MCC/HFP

DDS serves approximately 93,000 children ages 0-21 years. By law, regional centers cannot fund services that are funded by other public resources (i.e., MCC, HFP, WIC, mental health services, education, etc). Centers ask families whether children have a source of health insurance. Families with uninsured children are referred to apply for Medi-Cal and must indicate if they are ineligible, with varying levels of verification required, prior to having services that Medi-Cal benefits include paid for by the regional center.

#### <u>Uninsured Children Reached Through the Program</u>

At this time, it is unknown how many children served by the regional centers would potentially be eligible for MCC or HFP. The assumption is that children have private health insurance, have MCC or HFP, or have been determined ineligible for MCC, HFP, or other public resources.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. Regional centers not only have a legal mandate to seek other resources to pay for services, but also a fiscal incentive to help children enroll in health coverage programs.

There are a few possibilities. DDS is willing to explore conducting train-the-trainer sessions to educate regional center service coordinators about MCC/HFP and any facilitated referral processes. In addition, centers could receive packets of information about MCC/HFP designed to help them complete the referral process and answer parents' questions. They also could receive education and application materials for parents. In addition, DDS believes that regional centers can share family contact information with MCC/HFP for follow-up purposes as long as the parents understand and consent to this.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is promising. Some regional centers may be willing to provide on-site assistance in completing MCC/HFP applications.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not feasible. The DDS intake process is very detailed and involves review of medical records and clinical information. It is not a good match with other programs.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This is not feasible. Regional centers do not collect income information.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This is not feasible. Regional centers do not collect income information, and most likely would not want to expand their role to do so, even if by granting presumptive eligibility they could enable the immediate use of services that could be billed to Medi-Cal.

### Snapshot of Options

A, B

#### Child Welfare Services (CWS)

#### **Program Description**

Child Welfare Services (CWS) are provided to children and families on behalf of children alleged to be victims of child abuse, neglect or exploitation. These services may include, but are not limited to, case management, counseling, emergency shelter care, respite care, therapeutic day care, parenting training, and transportation. The service-funded activities are determined at the county level based upon individual child and family needs identified in the case plan.

Responsibility for administering Child Welfare Services is delegated by CDSS to county social services departments. The intake process is through referrals or calls coming in to the county welfare department alleging child abuse, neglect or exploitation. Upon referral, an Emergency Response Protocol process is completed by the social worker to determine whether an in-person investigation (a face-to-face response by the social worker) is required. The social worker is not required to initiate the Emergency Response Protocol when the social worker has already determined an in-person investigation is required (i.e., law enforcement referrals, obvious immediate danger referrals). The Emergency Response Protocol does not include information about family income or health insurance status. The Child Welfare Services Manual of Policies and Procedures, Division 31 Regulations, prohibits inquiry into income or status for the purpose of determining eligibility for emergency response services.

If it is determined that child welfare services are to be provided, the social worker completes an assessment for each child for whom services are to be provided, which includes gathering and evaluating information relevant to the case situation and apprising case service needs. The assessment documentation includes the need, if known, for any health/medical care. It does not include family income. Upon completion of the assessment, the social worker determines the case plan goal based on the following priority order, i.e., family maintenance services, family reunification services, or permanent placement services. The social worker then completes a case plan for the child. If the child is maintained at home (family maintenance services), the case plan is not required to address health information (i.e., name/address of provider, known medical problems, immunizations, and medications). However, this health information must be addressed in case plans for children receiving out-of-home care (e.g., family reunification or permanent placement services).

#### Current Linkages to MCC and HFP

County welfare departments usually ask about the health insurance status of children referred to CWS. Generally, uninsured children are referred to MCC or HFP; however, there is no information about the nature and extent of these referrals and whether there is any follow-up to ensure that MCC/HFP enrollment is completed. Furthermore, county welfare departments do not collect income information for children in CWS that could be used to screen for MCC/HFP income eligibility and shared with MCC/HFP with the family's permission. Information about children receiving CWS is maintained at the county level and in Child Welfare Services/Case Management System (CWS/CMS).

However, income information is generally not included; health information is addressed for children receiving out-of-home care.

#### Number of Children Potentially Reached Through Program

At the state level, it is not known how many children receiving CWS are uninsured. Furthermore, it is not known how many would be income eligible for MCC or HFP. It would be possible for county welfare departments to determine if a child in CWS was uninsured and likely eligible for MCC or HFP.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. County CWS staff could refer uninsured children to a Medi-Cal EW at the county. Another option would be for staff to give these families a standard referral form that would be forwarded by CWS staff to MCC/HFP SPE.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This option is not feasible for CWS due to limited social worker time and resources. County social worker time is 100 percent dedicated to developing and managing CWS caseloads.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not feasible since receipt of CWS is not based on application.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option is not feasible because county welfare departments do not collect income information for children in CWS that could be used to screen for MCC/HFP income eligibility and shared with MCC/HFP with the family's permission.

### Option E: Grant presumptive eligibility for MCC and/or HFP

This option is not feasible since CWS is neither a means-tested or provider-based program. Due to limited social worker time and resources, it would not be feasible for social workers to conduct the additional activities needed to grant presumptive eligibility.

#### Snapshot of Options

A, D (limited basis only)

#### Answers Benefiting Children (ABC) Project

#### Project Description

The Answers Benefiting Children Project (ABC) is a demonstration project funded jointly by the Office of Child Abuse Prevention (OCAP) and the Governor's Office of Criminal Justice Planning (OCJP). The project began in spring 1999 and will continue until June 2002.

The purpose of this project is to develop a model of service delivery that will maximize positive outcomes for children and families in terms of early intervention and the prevention of child abuse. Another objective of this project is to develop models of multi-agency cooperation that will impact the planning and delivery of child abuse and early intervention services through a countywide collaborative process. These collaborative processes should maximize the resources of public and nonprofit agencies, promote the integration and coordination of services, and serve as a nexus for local decision-making.

The ABC project consists of three program components: Child Abuse Treatment Service Program (CATS), Great Beginnings and Rural Outreach. Both CATS and Great Beginnings operate in each of the 17 participating ABC counties (San Diego, Orange, Santa Barbara, Kern, San Benito, Santa Cruz, Merced, San Mateo, Solano, Sacramento, El Dorado, Placer, Yuba, Yolo, Napa, Lake, and Shasta). The rural outreach component gave additional funding to four of the counties (Napa, Lake, Yuba, and San Benito) to provide ABC services in isolated communities.

The CATS program provides treatment services to child and adolescent victims of abuse and violence, who are under the age of eighteen, and to non-offending family members. Great Beginnings provides family support home visitation and Family Resource Center-based services for families with children ages 0-5. These services are designed to assist parents in managing the multiple tasks of parenthood and to provide structure, empowerment, and assistance with problem solving, coping, and resource utilization.

As part of Great Beginnings, home visitation services are focused upon the developmental needs of children, while assistance is provided to overburdened adults. A Multidisciplinary Team consisting of a Nurse, a Child Development Specialist, a Substance Abuse Specialist, and a Team Leader provides support and consultation to home visitors and direct services to families. Caseloads are limited to 25 families per home visitor and five home visitors are required. Family Resource Centers provide center- based services such as parent education, child development activities, resource and referral services, drop-in activities, support groups and mentoring programs as well as classes on topics such as anger management, communication skills, budgeting, and cooking. These classes are a part of the core services for ABC participants and are available to the community at large.

All ABC counties use a standard data system to maintain information collected through the Client Information and Family Information forms. Some counties collect family income data on these forms; other counties do not.

### Current Linkages to MCC/HFP

One of the objectives of the ABC project is to assist families in accessing medical services. As a result, the Multi-Disciplinary Team includes a nurse who is responsible for outreach and liaison with primary health care providers and who serves to connect families to a "medical home."

OCAP surveyed the 17 ABC projects about their efforts to help families enroll in MCC/HFP. Roughly 75% of the projects responded. About half of the respondents indicated that they refer families to other sources for assistance in completing the joint MCC/HFP application such as county social service departments and local CAAs. Often, home visitors support the family by providing translation services or providing transportation to the other locations that provide assistance. The other half of the respondents said that they provide on-site assistance with applications as part of a holistic approach to securing a "medical home" for all members of the family.

#### Number of Children Potentially Reached Through Program

It is unknown how many children who receive services through the ABC projects are uninsured and/or potentially income eligible for MCC or HFP. Information on health insurance status and family income may be collected and maintained by local ABC projects, but it is not submitted to OCAP.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This is a promising option. Currently, at least six ABC projects are providing MCC/HFP referrals. The referral process could be enhanced by having ABC projects use a standard referral form and providing them contact information for CAAs in their local areas. In addition, the process could be extended to other project sites.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This is a promising option. Currently, at least six ABC projects are currently providing on-site application assistance. This process could be enhanced by making more CAA training available to ABC projects.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not feasible because there is no common application used by all ABC projects. Intake procedures are already set and established locally.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option could be implemented on a limited basis by some ABC projects that collect family income information. OCAP can work with DHS/MR MIB to develop a uniform information release form that would allow ABC programs to share family contact information and possibly income information directly with MCC/HFP. The decision to use such a form would rest with the individual sites, since decisions of this nature are made locally.

## Option E: Grant presumptive eligibility for MCC/HFP

This option is not feasible as the ABC project is neither a means-tested or provider-based program.

#### Snapshot of Options

A, B, D (limited)

#### **Unemployment Insurance (UI) Program**

#### **Program Description**

The Unemployment Insurance (UI) program is administered by the Employment Development Department (EDD), and provides temporary wage replacement for persons unemployed through no fault of their own who remain available to work. More than \$3.4 billion in UI benefits are paid to claimants annually. UI provides weekly payments for unemployed workers, and requires that claimants be able to work, be seeking work, and be willing to accept a suitable job. UI is financed by unemployment program tax contributions from employers.

Claimants receive a benefit amount that is based upon their earnings in the base period. Currently, the maximum weekly benefit is \$230 per week and the minimum benefit is \$40 per week. Claimants can receive benefits for up to 26 weeks per claim period. The average duration of UI benefits is 13.1 weeks.

Claimants apply for UI benefits by phone via a toll-free number. Eligibility interviews are conducted by telephone by call center employees. Employers are given the opportunity to refute claimants' assertions of job loss circumstances. The application process will move to a web-based system in 18-24 months. Claimants may also apply for UI at One-Stop centers.

#### Current Linkages to MCC/HFP

There are no current linkages to MCC/HFP.

#### Number of Children Potentially Reached Through Program

The UI eligibility determination process does not include questions about a person's income, immigration status, or whether he/she has dependent children. It is not possible at this time to determine how many children of UI claimants might be uninsured and potentially eligible to MCC/HFP.

#### Possibilities for Implementing the Options

## Option A. Establish or enhance referral processes between other programs and MCC/HFP

This option is promising. Currently, UI does not refer claimants to other public programs. However, there are two possible ways in which UI could serve as a point of referral to MCC/HFP. One option is for UI to make the MCC/HFP joint application available to UI claimants in UI offices or through the mail. Another idea is for EDD to include a hyperlink on its website to MCC/HFP enrollment information.

# Option B. Provide education and on-site application assistance for MCC/HFP at the location of the other programs

This is not feasible because UI applications are taken over the telephone.

# Option C. Use a common paper-based or automated application to collect income and other eligibility information once for MCC, HFP and other programs

This is not seen as feasible because UI applications are taken over the telephone and no questions about income, property, immigration, or household composition are asked.

# Option D. Income and other eligibility information is shared with MCC/HFP and used to initiate the MCC/HFP application process

This option is not seen as promising since UI does not collect information on income.

### Option E: Grant presumptive eligibility for MCC/HFP

This option is not feasible since UI does not collect information on income and accepts applications over the telephone.

#### **Snapshot of Options**

Α

## Appendix F: Other States' Simplification and Streamlining Efforts

#### Florida

Florida is piloting an electronic application process targeted at Hispanic and Haitian children through day care centers. Incentives and application assistance fees will be offered to day care centers that assist families in completing electronic applications. A control group will be established among day care centers that do not assist families in completing applications. An evaluation will compare pre- and post-intervention differences between the control and experimental groups on variables such as the rate of enrollment, denial rate, and reasons for denials.

#### Massachusetts

Massachusetts's efforts focus on simplifying the re-determination process to reduce the number of administrative denials related to members not responding to the renewal mailings. The pilot, called "Member Express Renewal", will introduce a much simpler form that provides for self-dedaration and self-verification of income status. The "Member Express Renewal" process will also allow families, as well as individuals, to renew their Mass Health eligibility when they receive health care services at encounter locations, such as primary care providers' offices, by completing the forms and having them submitted directly from there to MassHealth. Children enrolled six months or longer will be specifically targeted for submitting the new renewal forms. A member who has successfully renewed through this process will have his or her re-determination anniversary date "rolled" forward for 12 months. Members subsequently will still be required to submit changes in their address, name, household composition, and earned income, which could result in their being re-determined at that time by the regular renewal process, as would information received by MassHealth through one of many electronic data matching sources. The evaluation of "Member Express Renewal" will assess the impact of the process on retention. It also is expected that the process will help to ensure continuity of care for MassHealth members by avoiding periods of ineligibility due to failure on the part of members to respond to the re-determination requirement.

#### Ohio

Ohio will pilot self-declaration of income at intake and re-determination in a limited geographic area. The evaluation will compare enrollment of persons who self-declare income with those who provide verification, and examine the impact on applicants' perceptions of the application process. The evaluation will also examine whether self-declaration prevents families from becoming eligible because they misreport income, and do not have a worker to confirm their statements against written verification.

#### <u>Pennsylvania</u>

Pennsylvania is piloting in Philadelphia a school-based health care enrollment effort. Currently, schools conduct outreach to identify uninsured children and offer them an application for Medicaid/SCHIP.

The pilot will add and test two interventions:

- Allowing self-declaration of income, and
- Intensive outreach, including follow-up by eligibility workers. The evaluation will identify the initial and long-term impacts of these interventions.

#### **Washington**

Washington's efforts focus on coordination between Medicaid and the NSLP. Currently, many Washington schools employ a multi-use NSLP application. The application includes an "opt-in" check-off box for families to authorize the NSLP program to share the child's contact and eligibility information with Medicaid. Washington will pilot a new NSLP application. This application will have an "opt-out" box that states that the child's contact and eligibility information will be shared with Medicaid unless the family checks the box. The pilot will also focus on improving the method used to crosscheck information provided by schools with the Medicaid eligibility system to identify children already on Medicaid. In the past, the state Medicaid agency had to check its eligibility system to see whether a child was already on Medicaid. For the pilot, the state will try to cross-match the NSLP data files with the Medicaid eligibility files. The evaluation will examine the number of children made eligible though this effort, as well as identify process improvements.

## Appendix G: Other States' Efforts with Presumptive Eligibility (PE)

#### New York

New York allows PE for children in its SCHIP program, CHPlus, and will soon allow PE in its Medicaid program. CHPlus is a managed care product that allows children to be covered the first of a month if they apply before the  $20^{th}$  of the previous month, even if they don't have all of the required documentation. Managed care plans can do PE pending enrollment for children who appear eligible, but they do not have all of the required documentation needed to make a final eligibility determination. The plans grant PE for 60 days, during which time they assist the family in obtaining missing documentation. In New York, a child may receive PE only once in a lifetime.

One problem New York is grappling with is the tendency for families not to provide needed documentation for enrollment during the PE period. Their children lose coverage after the 60-day period, and the application process begins all over again should the parents later seek health coverage. This time, the children go without health coverage pending enrollment.

### New Hampshire

New Hampshire's allows PE for children in its Medicaid program, called Healthy Kids Gold. The state has a variety of qualified entities (QEs) doing PE, including hospitals, child care centers, Head Start sites, WIC sites, family planning clinics, and community health centers. It does not currently allow individual clinician providers to do PE. The QEs assess if a child has an immediate medical need, and if so, assist the family in completing the Healthy Kids application. PE starts once the assessment is made and the application is completed. The QE site has five days to gather documentation from the child's family and forward it, along with the application, to the nearest Medicaid district office. The district office then has forty-five days to make an eligibility determination. Pending this determination, the child is considered presumptively eligible to Medicaid and can receive health care services under the fee-for-service program.

New Hampshire has found that the vast majority of PE cases are generated by hospitals and community health centers. A recent survey of QEs was just completed, and feedback from WIC, Head Start, and child care centers indicates that these sites worry that their agencies will be held financially responsible if a child turns out to be ineligible for Medicaid (this is not accurate as the state pays the PE costs for all ineligible children). Additionally, the survey found that sites that do PE frequently, like hospitals and health centers, have few problems with the PE process. Sites that do PE infrequently, like WIC and Head Start, find the PE process difficult. New Hampshire is also considering narrowing the scope of QEs to hospitals, community health centers, and perhaps adding individual clinician providers. Some decision makers at the State feel strongly that PE should be limited to children with immediate medical needs, and that medical providers could more correctly assess this. Another impetus for limiting the sites allowed to do PE is a feeling that many current QEs are not completing the PE process accurately. Therefore, there is a desire to limit the scope of participating Qes and to provide more training and monitoring to those that participate.

## New Jersey

New Jersey offers PE for children in both its Medicaid and SHCIP programs. QEs include acute care hospitals, federally qualified health centers, and local health departments with primary care centers. These sites complete a one-page PE application based upon a family's self-report of income and circumstances. No documentation is required. QEs forward the PE application to the state Medicaid office, which reviews the application and establishes temporary eligibility. The PE period runs until the end of the month following the month of application. Children are mailed a Medicaid card, and get services through the fee-for-service program. The family must follow up with the county welfare office or the state enrollment contractor to complete a full Medicaid application.

New Jersey indicated two principal findings in running their PE program. First, like New York, New Jersey has found that families tend not to follow through with enrollment after their child's immediate medical need has been met during the PE period. The state plans to facilitate enrollment by having PE providers help families complete the health coverage application onsite. Secondly, New Jersey feels strongly that QEs should be limited to health care providers, rather than allowing other program sites such as WIC, child care, etc. to do PE, to maintain control of the PE program and prevent abuse and fraud.

#### **Connecticut**

PE for children in Connecticut is a component of the Medicaid program. It was implemented in October 2000 as a pilot program operating in five school-based clinics. School nurses who identify a child without health insurance obtain information from the family about their income and fax it to the state Medicaid office for processing. The state office grants PE for forty-five days based upon this information, and completes a final eligibility determination during the PE period, contacting the family for additional information. Many of the difficulties Connecticut has encountered in bringing up their PE program involve coordination between the state Medicaid office and regional welfare departments. Still, the pilot is considered promising thus far and will be expanded after January 2001.

#### <u>Michigan</u>

Although PE for children was approved for Michigan's SCHIP program, the state is not enthusiastic about PE and does not plan to fully implement it. Due to serious concerns about fraud and program integrity, Michigan's process for approving an entity's request to do PE is very strict. State law allows managed care plans to do PE pending a final SCHIP eligibility determination, but in order to qualify, managed care plans must demonstrate a thorough understanding of Medicaid and SCHIP eligibility requirements. Plans must pass a written eligibility determination test using mock-up cases. To date, there have been a few plans interested in doing PE, but no plans have been able to pass the written test.

#### <u>Kentucky</u>

Although PE for its SCHIP program was approved, it has yet to be implemented.

## Appendix H: Impact of New Federal SCHIP regulations

New SCHIP regulations released in January 2001 and currently under review by the new administration impact Medi-Cal and HFP coordination.

Section 457.80 requires states to describe the procedures used to accomplish SCHIP coordination with other public and private health insurance programs and the methods used to ensure children are enrolled in the appropriate program to which they are eligible. HCFA has modified a corresponding section of the Medicaid regulations to require parallel coordination by Medicaid agencies with SCHIP. Section 431.636 concerns children who have applied for SCHIP and been screened as being potentially eligible for Medicaid. The regulations now require that the Medicaid agency have procedures in place to ensure applicants are not required to provide information or documentation already provided to SCHIP, to determine eligibility in a timely manner, to promptly notify SCHIP when a Medicaid eligibility determination has been made, and that the Medicaid agency facilitate SCHIP enrollment if the child is not eligible for Medicaid (at initial application and renewal).

Section 457.350 has been added to SCHIP rules to further clarify the screen and enroll requirements. Provisions that may impact Express Lane Eligibility options include a requirement that when the State finds an applicant who may be eligible for Medicaid, the State must promptly transmit the joint application or the application information to Medicaid, inform the applicant of potential Medicaid eligibility, and offer assistance in completing the Medicaid application process. The new regulations also state that when a child is screened potentially eligible for Medicaid and later found to be ineligible, SCHIP must determine eligibility without requiring the family to complete a new application.

## Appendix I: Eligibility Deeming

One approach to promote MCC/HFP enrollment that poses more challenges would be to "deem" a child to have met the eligibility requirements for participation in MCC/HFP if the child is enrolled in another designated program with similar eligibility requirements. A child could be deemed *income eligible* for MCC/HFP or *fully eligible* for MCC/HFP depending on how closely all of the program's eligibility requirements align with those of MCC/HFP. Background research conducted for this report indicates that no state has implemented a deeming model for their Medicaid or SCHIP programs. There are a variety of State and Federal regulations and statutes that affect the feasibility of income deeming or full-eligibility deeming.

## Income Deeming

Under income deeming, MCC/HFP would automatically determine that a child is income eligible for MCC/HFP if the child is enrolled in another designated program with similar income limits. Since many other programs, however, require less income information and documentation than MCC/HFP, income deeming could be very similar to allowing self-declaration of income for MCC/HFP.

Documentation of income and income deductions are required by Medicaid State statutes and regulations, and HFP state regulations, as illustrated in the chart below. Although Federal Medicaid and SCHIP statutes do not require documentation of income and income deductions, Federal statute (Section 1137 of the Social Security Act) and Federal regulations (42 Code of Federal Regulations, section 435.940 et sequitur,) require that states have an income and eligibility system (IEVS) for Medicaid. By requesting information from other Federal and State agencies, the state under IEVS must verify the applicant's income and resources to the extent that it is useful. Verification of self-declared income is required under the IEVS system. HCFA encourages states to randomly verify, after eligibility has been established, for income that cannot be checked under IEVS. In addition to Federal and State statutory and regulatory requirements, both MCC and HFP must follow their State Plan as reviewed and approved by HCFA.

Adopting a process of income deeming would require changes to Medicaid state statutes and regulations, and HFP state regulations. Furthermore, MCC and HFP would need to submit State Plan amendments to HCFA detailing the proposed changes to MCC and HFP for their review and approval. In addition to legal considerations, MCC/HFP would need to address logistical issues to allow income deeming.

If the State allows deeming of income eligibility for MCC/HFP and relies on IEVS for verification, the State would encounter the difficulty that data available through IEVS is a minimum of two quarters old. As a result, when MCC/HFP attempts to verify through IEVS an applicant's self-declared income from another program, IEVS could show a significantly different number from six to nine months prior. To ensure the program integrity of MCC/HFP, the State would need to establish guidelines to determine under what circumstances additional information would be requested from a family when self-reported income varies from IEVS data. MCC/HFP could either require additional documentation prior to starting coverage or start a child's coverage based on the self-

declared income information and conduct a post-enrollment verification. Either way, MCC/HFP would need to contact families and explain that they need to provide additional income information to begin or maintain their child's coverage. This process may be confusing or intimidating to applicants and may dissuade them or other programs from participating in the sharing of income information.

Another issue that would need to be addressed in any process of income deeming would be how MCC/HFP handle differences in family size between another program and MCC/HFP. For example, even if income information from the Food Stamps program is automatically accepted by MCC/HFP, Food Stamps counts family size differently than MCC/HFP. In order to adequately screen for Medi-Cal eligibility as required under federal SCHIP statute, HFP would need to recalibrate family size in accordance with MCC/HFP guidelines. As a result, family relationship information would need to be shared with MCC/HFP from another program or MCC/HFP would need to follow-up to request this information from the family.

#### Federal and State Documentation Requirements for MCC and HFP

DOCUMENTATIO N REQUIRED BY HFP/MCC APPLICATION	SCHIP FEDERAL STATUTE	PROPOSED SCHIP FEDERAL REGULATIONS	HFP STATE STATUTES	HFP STATE REGULATIONS	MEDICAID FEDERAL STATUTE	MCC STATE STATUES	MCC STATE REGULATIONS
Income	NO	NO	NO	YES	NO <sup>1,2</sup>	YES	YES
Income Deductions	NO	NO	NO	YES	NO <sup>1,2</sup>	YES	YES
Birth Certificate (Citizenship) 3	NO	NO	NO	YES	NO	NO	NO
Immigration Status <sup>4</sup>	YES⁵	YES	YES	YES	YES	YES <sup>6</sup>	YES
Residency	NO	NO	NO	YES	NO	YES	YES
Pregnancy	NO	NO	NO	NO	NO <sup>7</sup>	NO <sup>8</sup>	YES
Identity	NO	NO	NO	NO	NO	NO	YES

#### Full Eligibility Deeming

Under full eligibility deeming, MCC/HFP would automatically determine that a child is eligible for MCC/HFP if the child is enrolled in another designated program. This approach is limited by the Federal and State requirement that MCC and HFP must collect documentation of immigration status. Currently, MCC/HFP allow a family to provide immigration documentation within 30 days of a child's enrollment. A similar approach could be adopted in deeming full eligibility in that a child could be enrolled in MCC/HFP if he or she is enrolled in another designated program, and the family would provide proof of the child's immigration status within 30 days of the child's enrollment in MCC/HFP. Similar to income deeming, the issues of verification of income and the recalibration of family size according to MCC/HFP rules would need to be addressed under full eligibility deeming. Furthermore, State regulations governing other requirements such as citizenship, pregnancy, and identity would need to be revised.

<sup>5</sup> Immigration verification requirements for SCHIP are contained in the Personal Responsibility and Work Opportunity Act

<sup>1</sup> Section 1137 of the Social Security Act requires states to have an income and eligibility system (IEVS). By requesting information from other federal and state agencies, the state under IEVS must verify the applicant's income and resources to the extent that it is useful. Verification of self-declared income is required under the IEVS system. HCFA encourages states to randomly verify, after eligibility has been established, for income that cannot be checked under IEVS.

242 Code of Federal Regulations, section 435.940 et sequitur, requires states to conduct specified activities to very self-declared

income and income deductions.

For HFP, a birth certificate may either be submitted at the time of application or within 60 days from the date of enrollment in HFP. <sup>4</sup> Immigration documentation may be submitted at the time of application or within 30 days from the date of enroll ment in HFP or

<sup>(</sup>PRWORA).

6 Documentation of immigration status is required unless an alien who does not have immigration documentation is applying for

<sup>&</sup>lt;sup>7</sup> Federal regulations require that pregnancy be "medically verified" for pregnant women under certain circumstances (42 C.F. R, section 435.116), including pregnant women applying for benefits using the MCC/HFP joint application.

State statute, Welfare & Institutions Code 14011.15, allows self-verification of pregnancy for applicants using the simplified mail-in

application to the extent allowable by federal law.

Appendix J: List Of Acronyms

	Appendix 3. List Of Actoriyins		
ABC Project	Answers Benefiting Children Project		
ADP	Alcohol and Other Drug Programs		
CAA	Certified Application Assistant		
CalWORKs	California Work Opportunity and Responsibility to Kids Program		
CBO	Community-Based Organization		
CCFP	Child Care Food Program		
CDE	California Department of Education		
CHDP	Child Health and Disability Prevention		
CHHS	California Health and Human Services Agency		
CWD	County Welfare Department		
DCSS	State Department of Child Support Services		
DDS	California Department of Development Services		
DHS	California Department of Health Services		
DMH	California Department of Mental Health		
DSS	California Department of Social Services		
EDD	Employment Development Department		
EDS	Electronic Data Systems		
EPSDT	Early Periodic Screening Diagnosis and Treatment Program		
EW	Eligibility Worker		
Family PACT	Family Planning, Access, Care and Treatment Program		
FDPIR	Food Distribution Program on Indian Reservations		
FPL	Federal Poverty Level		
HCFA	Health Care Financing Administration		
HFP	Healthy Families Program		
IEVS	Income Eligibility and Verification System		
INS	Immigration and Naturalization Service		
MCC	Medi-Cal for Children		
MEDS	Medi-Cal Eligibility Data Systems		
MRMIB	Managed Risk Medical Insurance Board		
NOA	Notice of Action		
NSLP	Inc. 101 II 15		
PE	National School Lunch Program		
	Presumptive Eligibility		
SCHIP	<u> </u>		
SCHIP SGF	Presumptive Eligibility		
	Presumptive Eligibility State Children's Health Insurance Program		
SGF	Presumptive Eligibility State Children's Health Insurance Program State General Fund		
SGF SPE	Presumptive Eligibility State Children's Health Insurance Program State General Fund Single Point of Entry		